"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

The ABNs and NOMNCs
What, Why, How and When?

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ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

Agenda

ABNs and NOMNCs

Agenda

- Beneficiary Notification Initiative (BNI)
- Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)
- Medicare Part B ABN (CMS-R-131)
- Notice of Medicare Non-Coverage (NOMNC)/Generic Notice
- Detailed Notice
- Survey guidance
- Q&A

Resource List

- Beneficiary Notification Initiative webpage
- Medicare Claims Processing Manual Chapter 30, Financial Liability Protections
- State Operations Manual Appendix PP
- Survey Critical Element Pathways Beneficiary Notice

Financial Liability Protections

- The Financial Liability Protections (FLP) provisions of the Social Security Act protect beneficiaries, healthcare providers, and suppliers under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay.
- The FLP provisions apply after an item or service's coverage determination is made.
- In most cases, the FLP provisions apply only to beneficiaries enrolled in the Original Medicare Fee For Service (FFS) program Parts A and B.
- The FLP provisions apply only when both of the following are met:
  - Items and/or services are denied on the basis of specific statutory or regulatory provisions.; **and**
  - Involve determinations about beneficiary and/or healthcare provider/supplier knowledge of whether Medicare was likely to deny payment for the items and/or services.
- The Limitation On Liability provisions (LOL) apply to all Part A services and all assigned claims for Part B services.

Financial Liability Protections

- Application of the LOL provisions depends, in part, whether the beneficiary and/or the healthcare provider or supplier knew or could reasonably have been expected to know that the item or service was not covered.
- In other words, if a claim is denied, liability must be established. Who is responsible for the bill?
- The 4 notices of non-coverage that apply to services provided in a SNF establish both knowledge and liability.

Advance Beneficiary Notices (ABNs)

- The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice.
- Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative.
- In all cases, the notifier must retain a copy of the ABN delivered to the beneficiary on file.

Effective Notification (ABN)

- ABN delivery is considered to be effective when the ABN is:
  - Delivered by a suitable notifier to a capable recipient and comprehended by that recipient.
  - Provided using the correct OMB approved notice with all required blanks completed. Failure to use the correct notice may lead to the notifier being found liable since the burden of proof is on the notifier to show that knowledge was conveyed to the beneficiary according to CMS instructions.
  - Delivered to the beneficiary in person if possible.
  - Provided far enough in advance of delivering potentially non-covered items or services to allow sufficient time for the beneficiary to consider all available options.
  - Explained in its entirety, and all of the beneficiary's related questions are answered timely, accurately, and completely to the best of the notifier's ability.
    - The notifier should direct the beneficiary to call 1-800-MEDICARE if the beneficiary has questions s/he cannot answer. If a Medicare contractor finds that the notifier refused to answer a beneficiary's inquiries or direct them to 1-800-MEDICARE, the notice delivery will be considered defective, and the notifier will be held financially liable for non-covered care.
  - Signed by the beneficiary.

Period of Effectiveness (ABN)

- An ABN remains effective after valid delivery so long as there has been no change in:
  - Care from what is described on the original ABN;
  - The beneficiary's health status which would require a change in the subsequent treatment for the non-covered condition; and/or
  - The Medicare coverage guidelines for the items or services in question (i.e., updates or changes to the policy of an item or service).

  NOTE: If any of the above changes during the course of treatment, a new ABN must be issued.

Options for Delivery (ABN)

- ABNs should be delivered in-person and prior to the delivery of medical care which is presumed to be non-covered. In circumstances when in-person delivery is not possible, notifiers may deliver an ABN using another method. Examples include:
  - Direct telephone contact;
  - Mail;
  - Secure fax machine; or
  - Internet e-mail.
- All methods of delivery require adherence to all statutory privacy requirements under HIPAA. The notifier must receive a response from the beneficiary or his/her representative in order to validate delivery.

Options for Delivery (ABN)

- When delivery is not in-person, the notifier must verify that contact was made in his/her records.
- In order to be considered effective, the beneficiary should not dispute such contact.
- Telephone contacts should be followed immediately by either a hand-delivered, mailed, emailed, or a faxed notice.
- The beneficiary should sign and retain the notice and send a copy of this signed notice to the notifier for retention in the patient's record.
- The notifier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice.
- If the beneficiary does not return a signed copy, the notifier should document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself.

Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)

- A SNF ABN is evidence of beneficiary knowledge about the likelihood of a Medicare denial, for the purpose of determining financial liability for expenses incurred for extended care items or services furnished to a beneficiary and for which Medicare does not pay.
- If Medicare is expected to deny payment (entirely or in part) for extended care items or services that the SNF furnishes to a beneficiary, a SNF ABN must be given to the beneficiary in order to transfer financial liability for the item or service to the beneficiary.
- The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A)

SNF ABN Triggering events

EVENT	DESCRIPTION
Initiation	In the situation in which a SNF believes Medicare will not pay for extended care items or services that a physician has ordered, the SNF must provide a SNF ABN to the beneficiary before it furnishes those non-covered extended care items or services to the beneficiary.
Reduction	In the situation in which a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide a SNF ABN to the beneficiary before it reduces items or services to the beneficiary.
Termination	In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF must provide a SNF ABN to the beneficiary before it terminates such extended care items or services.

Generally, the only time a SNF ABN will be initiated in a SNF is when a resident stays in the facility for non-covered care after a Part A stay.

SNF ABN Triggering events

- The SNFABN can be used as a voluntary notice and replaces the Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF). There are no specific requirements for notice completion when the SNFABN is issued voluntarily, and alternatively, SNFs may develop their own written notice for care that is never covered. When the SNFABN is being issued as a voluntary notice, the beneficiary doesn't need to select an option box or provide a signature.
- SNFs are not required to give written notice prior to providing care that Medicare never covers, such as care that is statutorily excluded or care that fails to meet a benefit requirement; however, as a courtesy to the beneficiary and to forewarn him/her of impending financial obligation, SNFs are encouraged to give notice.

Example:

Care: Inpatient Skilled Nursing Facility Stay

Reason Medicare May Not Pay: Medicare won't pay for your stay at this facility because you don't have a qualifying 3-day inpatient hospital stay;

Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)

- SNFs need not issue a SNF ABN to transfer financial liability to the beneficiary:
  - If the extended care item or service is not a Medicare benefit. (e.g., personal comfort items excluded under §1862(a)(6)).
  - If a beneficiary is being furnished post-hospital extended care services while a resident in a SNF and payment is expected to be denied for an otherwise Medicare covered benefit because it does not meet a technical benefit requirement (e.g., SNF stay not preceded by the required prior three-day hospital stay or the beneficiary is exhausting his/her 100 benefit days).
  - If Medicare is expected to deny payment for Part B covered medical and other health services which the SNF furnishes, either directly or under arrangements with others, to an inpatient of the SNF, where payment for these services cannot be made under Part A (e.g., the beneficiary has exhausted his/her allowed days of inpatient SNF coverage under Part A in his/her current spell of illness or was determined to be receiving a non-covered level of care).

Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)

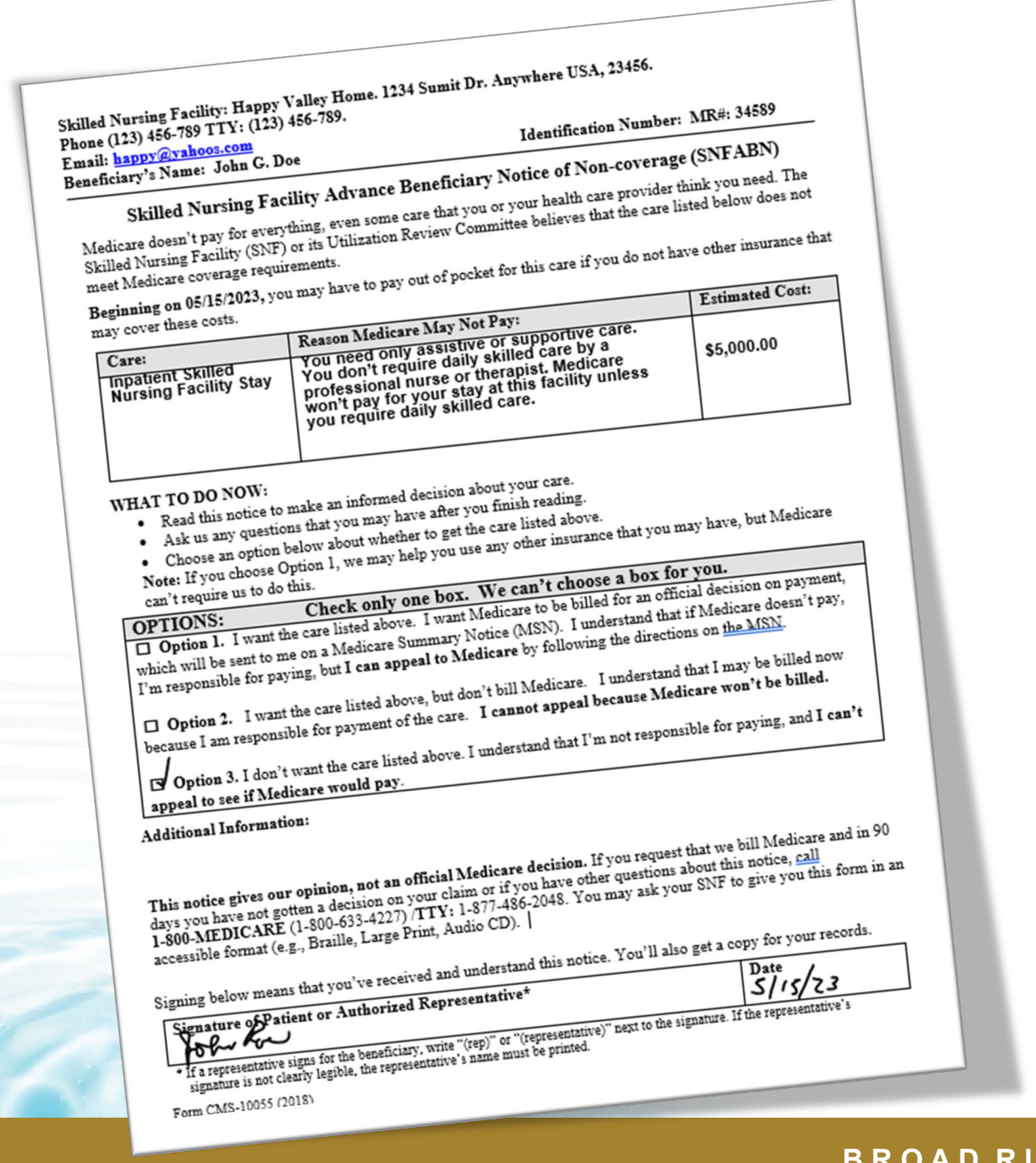
- SNFs need not issue a SNF ABN to transfer financial liability to the beneficiary cont.):
  - If the SNF will not furnish the extended care items or services. A SNF must not give a beneficiary a SNF ABN and then refuse to furnish extended care items or services even though the beneficiary elects to receive these items or services

    NOTE: This rule is not applicable in the situation where the beneficiary elects to receive extended care items or services but refuses to sign the SNF ABN attesting to being personally and fully responsible for payment, in which case, the SNF may then consider not furnishing the specified items or services.
  - For Medicare Advantage (Part C) enrollees nor for non-Medicare patients because it is to be used solely for individuals enrolled in the Medicare FFS program.
  - When extended care items or services are reduced or terminated in accordance with a physician's order, where a physician does not order the items or services at issue, or where the physician agrees in writing with the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that the extended care items or services are not necessary.
  - For swing-bed determinations.

Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)

- SNFs need not issue a SNF ABN to transfer financial liability to the beneficiary cont.):
  - The beneficiary exhausts the SNF benefits coverage (100 days), thus exhausting their Medicare Part A SNF benefit.
  - The beneficiary initiates the discharge from the SNF.
  - The beneficiary elects the hospice benefit or decides to revoke the hospice benefit and return to standard Medicare coverage.

Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)



Skilled Nursing Facility: Happy Valley Home. 1234 Sumit Dr. Anywhere USA, 23456.
Phone (123) 456-789 TTY: (123) 456-789.
Email: happy@yahoos.com
Beneficiary's Name: John G. Doe Identification Number: MR#: 34589

Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on 05/15/2023, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

Care:	Reason Medicare May Not Pay:	Estimated Cost:
Inpatient Skilled Nursing Facility Stay	You need only assistive or supportive care. You don't require daily skilled care by a professional nurse or therapist. Medicare won't pay for your stay at this facility unless you require daily skilled care.	$5,000.00

WHAT TO DO NOW:

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

OPTIONS: Check only one box. We can't choose a box for you.

☐ **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

☐ **Option 2.** I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare won't be billed.**

☑ **Option 3.** I don't want the care listed above. I understand that I'm not responsible for paying, and **I can't appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY:** 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

Signature of Patient or Authorized Representative*	Date
John Doe	5/15/23

* 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 CMS-10055 (2018)

Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)

- When a SNF ABN is properly executed and given timely to a beneficiary and Medicare denies payment on the related claim, the SNF must wait for the beneficiary to receive a Medicare Summary Notice (MSN) before it can collect payment on the related claim.
- Medicare does not limit the amount that the SNF may collect from the beneficiary in such a situation.
- A beneficiary's agreement to "be personally and fully responsible for payment" means that the beneficiary agrees to pay out of pocket or through any other insurance that the beneficiary may have, e.g., through employer group health plan coverage, through Medicaid, or through some other Federal or non-Federal payment source.

Advance Beneficiary Notice (CMS-R-131)

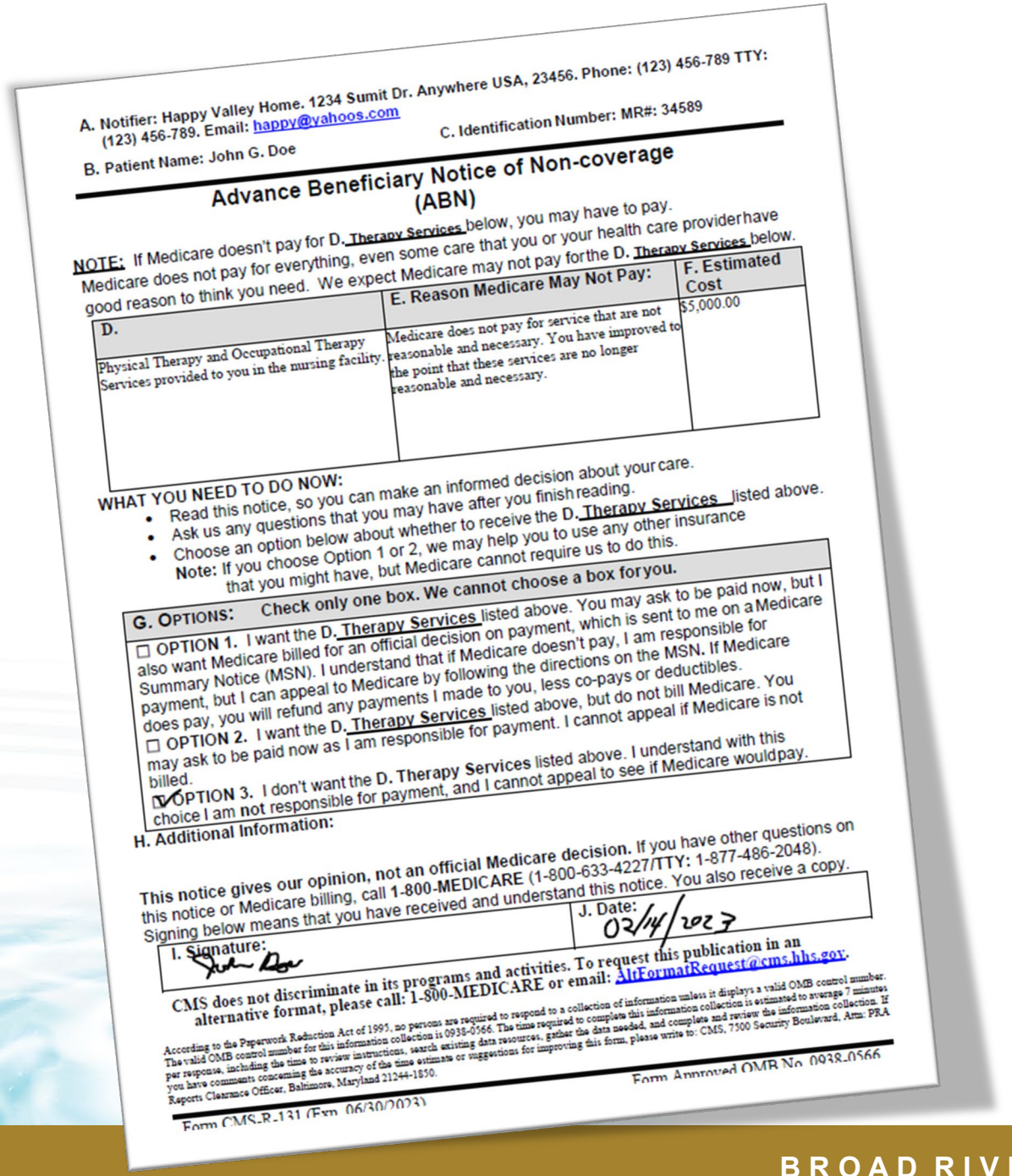
- Skilled Nursing Facilities (SNFs) issue CMS-R-131 for Part B services only.
- SNFs must complete the CMS-R-131 in order to transfer potential financial liability to the beneficiary and deliver the notice prior to providing the items or services that are the subject of the notice.

CMS-R-131 Triggering events

Generally, there are only too triggering events related to issuing CMS-R-131 in a SNF.

Reductions	Terminations
A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.). The ABN is not issued every time an item or service is reduced. But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued	A termination is the discontinuation of certain items or services. The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.

Advance Beneficiary Notice (CMS-R-131)



A. Notifier: Happy Valley Home. 1234 Sumit Dr. Anywhere USA, 23456. Phone: (123) 456-789 TTY: (123) 456-789. Email: happy@yahoos.com

B. Patient Name: John G. Doe

C. Identification Number: MR#: 34589

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. Therapy Services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. Therapy Services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy and Occupational Therapy Services provided to you in the nursing facility.	Medicare does not pay for service that are not reasonable and necessary. You have improved to the point that these services are no longer reasonable and necessary.	$5,000.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. Therapy Services listed above.
- **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. Therapy Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. Therapy Services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☑ **OPTION 3.** I don't want the D. Therapy Services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
[signature]	02/14/2023

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Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

Advance Beneficiary Notice (CMS-R-131)

- A beneficiary's agreement to be responsible for payment on an ABN means that the beneficiary agrees to pay for expenses out-of-pocket or through any insurance other than Medicare that the beneficiary may have.
- The notifier may bill and collect funds from the beneficiary for non-covered items or services immediately after an ABN is signed, unless prohibited from collecting in advance of the Medicare payment determination by other applicable Medicare policy, State or local law.
- Regardless of whether they accept assignment or not, healthcare providers and suppliers are permitted to charge and collect the usual and customary fees; therefore, funds collected are not limited to the Medicare allowed amounts.
- If Medicare ultimately denies payment of the related claim, the notifier retains the funds collected from the beneficiary unless the claim decision finds the healthcare provider or supplier liable.
- When Medicare finds the healthcare provider or supplier liable or if Medicare or a secondary insurer subsequently pays all or part of the claim for items or services previously paid by the beneficiary to the notifier, the notifier must refund the beneficiary the proper amount in a timely manner.

Advance Beneficiary Notice (CMS-R-131)

NOTE: Dually Eligible beneficiaries must be instructed to check **Option Box 1** on the ABN in order for a claim to be submitted for Medicare adjudication.

Strike through **Option Box 1** as provided below:

□ **OPTION 1.** I want the (D) listed above. ~~You may ask to be paid now, but~~ I ~~also~~ want Medicare billed for an official decision on payment, which is sent to me

on a Medicare Summary Notice (MSN). ~~I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN.~~

These edits are required because the provider cannot bill the dual eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal law affecting coverage and billing of dual eligible beneficiaries. If Medicare denies a claim where an ABN was needed in order to transfer financial liability to the beneficiary, the claim may be crossed over to Medicaid or submitted by the provider for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue a Remittance Advice based on this determination.

Advance Beneficiary Notice (CMS-R-131)

- Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in the following circumstances:
  - If the beneficiary has QMB coverage without full Medicaid coverage, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy.
  - If the beneficiary has full Medicaid coverage and Medicaid denies the claim (or will not pay because the provider does not participate in Medicaid), the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice)

- Section 1869(b)(1)(F) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554) granted beneficiaries in Original Medicare the right to an expedited determination process to dispute the end of their Medicare covered care in certain provider settings.
- The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in SNFs, HHAs, CORFs and Hospice.
  - **Skilled Nursing Facilities (SNFs)--** Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy). A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending. For example, a beneficiary exhausts the SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives physical and occupational therapy covered under Medicare Part B. A NOMNC must be delivered by the SNF when both Part B therapies are ending.
- Skilled Nursing Facilities includes beneficiaries receiving Part A and B services in Swing beds.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice)

- The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.
  - When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).
  - When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).
  - When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).
  - When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).
  - When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).
  - When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) - Delivery

- Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process
- A NOMNC must be delivered even if the beneficiary agrees with the termination of services.
- The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.
- If the beneficiary refuses to sign the NOMNC the provider should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the NOMNC remain entitled to an expedited determination.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) - Delivery

- CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative.
- Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification.
- Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact.
- If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) - Delivery

- The date of the conversation is the date of the receipt of the notice.
- Confirm the telephone contact by written notice mailed on that same date.
- When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested.
- The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt.
- Place a dated copy of the notice in the enrollee's medical file.
- When notices are returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the provider's mailing date.
- The NOMNC should be clearly annotated with the following information in these situations.
  - Reflect that all information on the NOMNC was communicated to the representative;
  - Note the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) - Delivery

- A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the beneficiary's medical file.
- If the provider chooses to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS) The burden is on the provider to demonstrate that timely contact was attempted with the representative and that the notice was delivered.
- The date that someone at the representative's address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary's medical file.
- If both the provider and the representative agree, providers may send the notice by fax or e-mail, however, providers fax and e-mail systems must meet the The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) – Delivery

- If a Qualified Independent Contractor (QIO) determines that a provider did not deliver a valid NOMNC to a beneficiary, the provider is financially liable for continued services until two days after the beneficiary receives valid notice, or until the effective date of the valid notice, whichever is later.
- If the initial NOMNC was delivered to a beneficiary and the effective date was changed, the provider may amend the notice to reflect the new date. The newer effective date may not be earlier than the effective date of the original notice except in those cases involving the abrupt end of services.
- The beneficiary must be verbally notified as soon as possible after the provider is aware of the change. The amended NOMNC must be delivered or mailed to the beneficiary and a copy retained in the beneficiary's file.
- If an expedited determination is already in progress, the provider must immediately notify the QIO of the change and provide an amended notice to the QIO.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) – Delivery

- The provider must retain the original signed NOMNC in the beneficiary's file.
- The beneficiary should receive a paper copy of the NOMNC that includes all of the required information such as the effective date and covered service at issue.
- Electronic notice retention is permitted if the NOMNC was delivered electronically.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) – Timeframes

- The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end.
  - **For example**, if the last day of covered SNF care is a Friday, the NOMNC should be delivered no later than the preceding Wednesday.
- The NOMNC may be delivered earlier than two days preceding the end of covered services.
- However, delivery of the notice should be closely tied to the impending end of coverage so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination.
- The notice may not be routinely given at the time services begin. An exception is when the services are expected to last fewer than two days. In these instances, the notice may be given by the provider when services begin.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) – Timeframes

- A beneficiary who receives a NOMNC and disagrees with the termination of services may request an expedited determination by the appropriate QIO for the state where the services were provided.
- The beneficiary must contact the QIO by noon of the day before the effective date on the NOMNC. The beneficiary may contact the QIO by telephone or in writing.
- If the QIO is unable to accept the request, the beneficiary must submit the request by noon of the next day the QIO is available.
- The beneficiary must be available to answer questions or supply information requested by the QIO. The beneficiary may, but is not required to, supply additional information to the QIO that he or she believes is pertinent to the case.
- If the beneficiary makes an untimely request to the QIO, the QIO will accept the request for review, but is not required to complete the review within its usual 72-hour deadline. The QIO will make a determination as soon as possible upon receipt of the request.

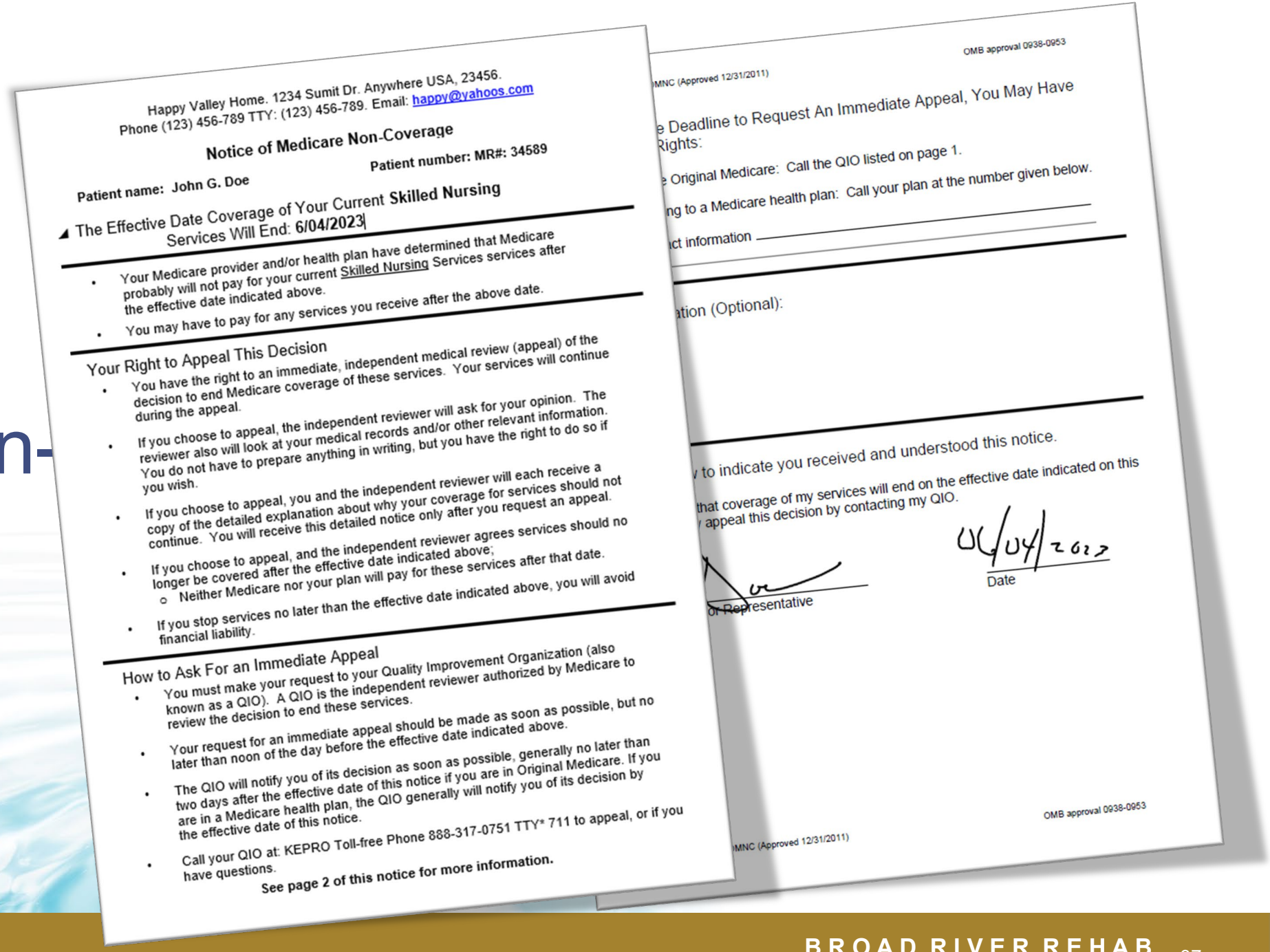
Notice of Medicare Non-Coverage (NOMNC/Generic Notice) – Timeframes

- Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request.
- When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request.
- Coverage protections do not apply to a beneficiary who makes an untimely request to the QIO.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) – Timeframes

- When a provider is notified by a QIO of a beneficiary request for an expedited determination, the provider must:
  - Deliver the beneficiary a DENC by close of business the day they are notified;
  - Supply the QIO with copies of the NOMNC and DENCs by close of business of the day of the QIO notification;
  - Supply all information, including medical records, requested by the QIO. The QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record; **and**
  - Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the QIO. The provider may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.

Notice of Medicare Non-Coverage (NOMNC)



Happy Valley Home. 1234 Sumit Dr. Anywhere USA, 23456.
Phone (123) 456-789 TTY: (123) 456-789. Email: happy@yahoos.com

Notice of Medicare Non-Coverage

Patient name: John G. Doe **Patient number: MR#: 34589**

The Effective Date Coverage of Your Current **Skilled Nursing** Services Will End: **6/04/2023**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing Services services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO Toll-free Phone 888-317-0751 TTY* 711 to appeal, or if you have questions.

See page 2 of this notice for more information.

MNC (Approved 12/31/2011)

OMB approval 0938-0953

e Deadline to Request An Immediate Appeal, You May Have
Rights:

Original Medicare: Call the QIO listed on page 1.

ng to a Medicare health plan: Call your plan at the number given below.

ct information _____

ation (Optional):

to indicate you received and understood this notice.

that coverage of my services will end on the effective date indicated on this
appeal this decision by contacting my QIO.

06/04/2023

Date

or Representative

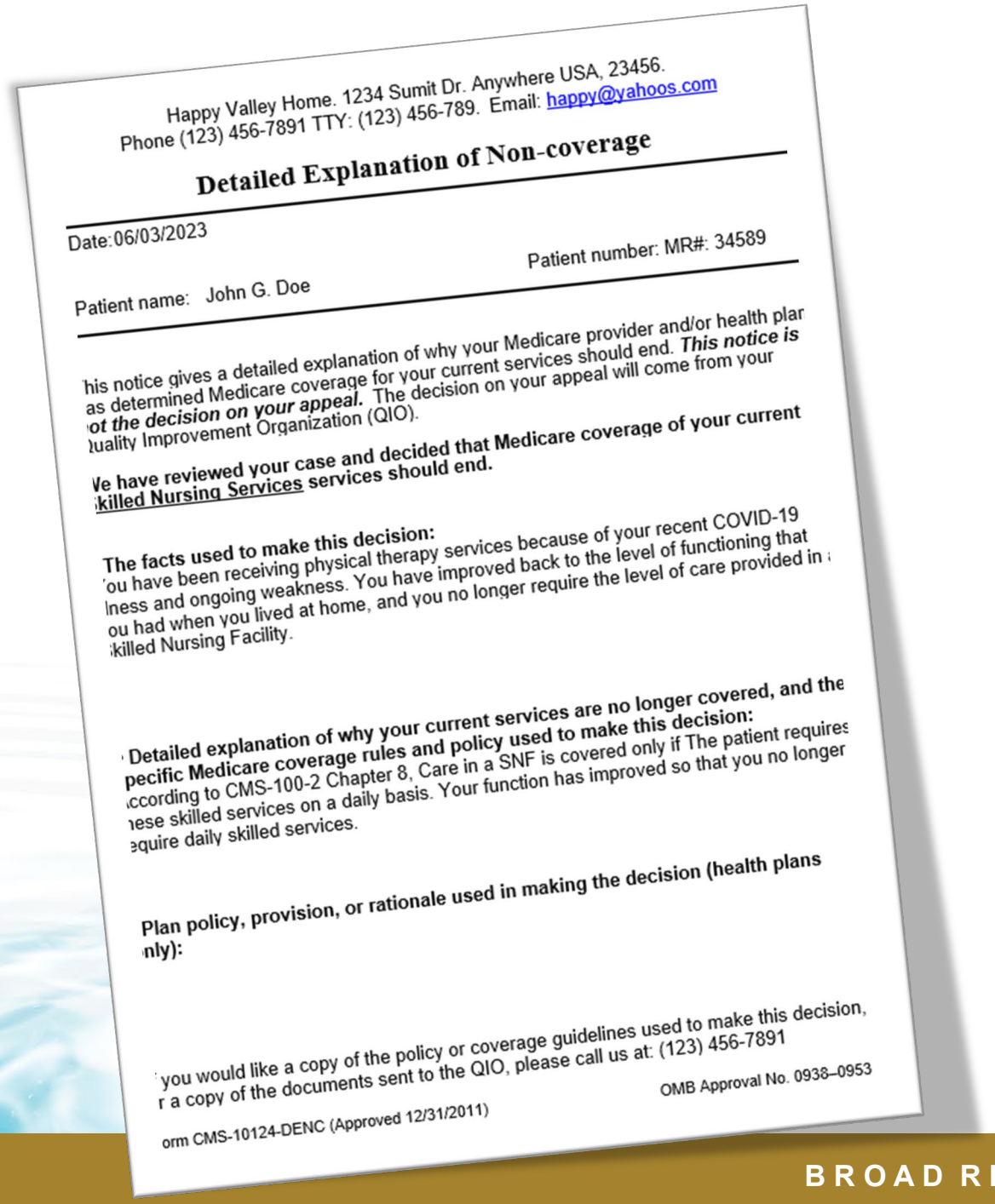
MNC (Approved 12/31/2011)

OMB approval 0938-0953

Detailed Notice of Non-Coverage (DENC/Detailed Notice) – Timeframes

- The delivery of the DENC must occur in person by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination.
- A provider may also choose to deliver the DENC with the NOMNC.
- The DENC does not require a signature but should be annotated in the event of a beneficiary's refusal to accept the notice upon delivery.

Detailed Notice of Non-Coverage (DENC)



Happy Valley Home. 1234 Sumit Dr. Anywhere USA, 23456.
Phone (123) 456-7891 TTY: (123) 456-789. Email: happy@yahoos.com

Detailed Explanation of Non-coverage

Date:06/03/2023

Patient name: John G. Doe

Patient number: MR#: 34589

his notice gives a detailed explanation of why your Medicare provider and/or health plar as determined Medicare coverage for your current services should end. ***This notice is ot the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current Skilled Nursing Services services should end.

The facts used to make this decision:
You have been receiving physical therapy services because of your recent COVID-19 lness and ongoing weakness. You have improved back to the level of functioning that ou had when you lived at home, and you no longer require the level of care provided in Skilled Nursing Facility.

Detailed explanation of why your current services are no longer covered, and the pecific Medicare coverage rules and policy used to make this decision:
ccording to CMS-100-2 Chapter 8, Care in a SNF is covered only if The patient requires ese skilled services on a daily basis. Your function has improved so that you no longer equire daily skilled services.

Plan policy, provision, or rationale used in making the decision (health plans nly):

you would like a copy of the policy or coverage guidelines used to make this decision, r a copy of the documents sent to the QIO, please call us at: (123) 456-7891

orm CMS-10124-DENC (Approved 12/31/2011)

OMB Approval No. 0938–0953

CMS Expedited Determination Scenario in a Skilled Nursing Facility - Example

On June 2nd, the SNF delivers a NOMNC to Bob Mills notifying him that his Medicare covered stay will end on June 4th. Bob decides to request an expedited determination.

June 2nd	June 3nd	June 4rd	June 5th	June 6th
NOMNC Delivered Bob receives a NOMNC indicating that his coverage is ending June 4th.	**Bob must** request an expedited determination by noon today.	**NOMNC Effective Date** This is the last day of coverage, as stated on the NOMNC.	**If Bob made his request on June 2nd:** The QIO makes its decision and notifies Bob and the SNF by COB.	**If Bob made his request on June 3rd:** The QIO makes its decision and notifies Bob and the SNF by COB.
	The QIO must notify the SNF of Bob's request for an expedited determination. **The SNF must deliver the DENC to Bob by COB today.** **The SNF must provide relevant medical records to the QIO by COB today.**	**The beneficiary has no liability for this day as this is the last day of coverage in the SNF.**	**If QIO decision is unfavorable:** Beginning today Bob is liable for his stay if he does not leave the SNF.	

Quality Improvement Organization (QIO) – Timeframes

- QIOs must be available to receive beneficiary requests for review 24 hours a day, 7 days a week.
- When the QIO receives a request from a beneficiary, the QIO must immediately notify the provider of services that a request for an expedited determination was made. If the request is received after normal working hours, the QIO should notify the provider as soon as possible on the morning after the request was made.
- The QIO must validate that the NOMNC included the required elements outlined below:
  - Date that coverage of services ends.
  - Date that beneficiary's financial liability begins.
  - Description of right to an expedited determination (and how to request an expedited determination) and the right to submit relevant information to the QIO.
  - Right to detailed information on why the provider believes Medicare will no longer cover services.
  - Contact information for QIO in the state where services were delivered.

Quality Improvement Organization (QIO) – Timeframes

- The QIO should determine that NOMNC delivery was valid if all of the following criteria are met:
  - All elements stated above are included.
  - The beneficiary signed and dated the notice. If the NOMNC was annotated because the beneficiary refused to sign the notice upon delivery, the QIO may still conduct an expedited determination in these instances.
  - Notice was delivered at least two days before services terminate.
- Invalidating a NOMNC should be a rare occurrence. The only reasons to invalidate are the lack of one of the criteria stated above or a pattern of minor errors as established by the provider.
- If a QIO invalidates a NOMNC, a new NOMNC must be issued to the beneficiary with an effective date at least two days after the beneficiary receives valid notice. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

Quality Improvement Organization (QIO) – Timeframes

- The QIO must solicit the views of the beneficiary who requested the expedited determination.
- The QIO must afford the provider an opportunity to explain why the discharge is appropriate.
- No later than 72 hours after receipt of the request for an expedited determination, the QIO must make its determination on whether the discharge is appropriate based on medical necessity or other Medicare coverage policies.
- **Note:** If the QIO does not receive supporting information from the provider, it may make its determination based on the evidence at hand, or defer a decision until it receives the necessary information. If this delay results in continued services for the beneficiary, the provider may be held financially liable for these services as determined by the QIO.

Quality Improvement Organization (QIO) – Timeframes

- The QIO must notify the beneficiary, the beneficiary's physician, and the provider of services of its determination.
- This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability. QIOs must also inform the beneficiary of the right to an expedited reconsideration by the Qualified Independent Contractor (QIC) and how to request a timely expedited reconsideration.
- The QIO will make its initial notification via telephone and will follow up with a written determination letter.
- The QIO determination is binding unless the beneficiary pursues an expedited reconsideration See section 270 of CMS 100-4 Chapter 30.
- If dissatisfied with the expedited determination, the beneficiary may request an expedited reconsideration

Other Considerations

- If the QIO decision extends coverage to a period where a physician's orders do not exist, either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care, providers cannot deliver care.
- In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders.
- The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider.
- The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.

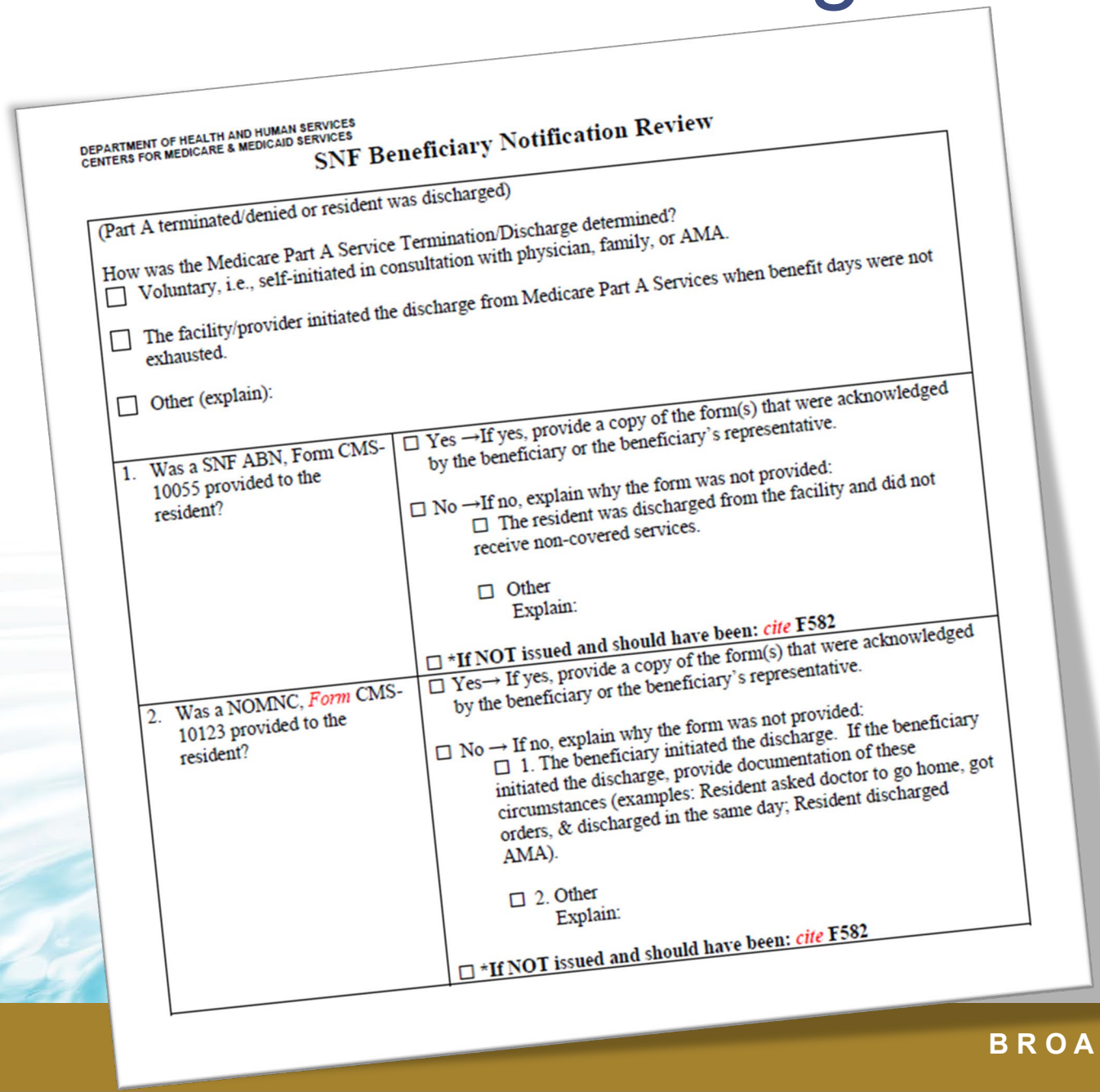
Other Considerations

- If a QIO decision is favorable to the beneficiary and the beneficiary resumes covered services, a new NOMNC should be delivered if that care is later terminated, per the requirements of this section.
- If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.
- The QIO decision will affect the necessity of subsequent Advance Beneficiary Notice of Noncoverage (ABN) deliveries.
  - **Example:** If covered Skilled Nursing Facility (SNF) care continues following a favorable QIO decision for the beneficiary but later ends due to the end of Medicare coverage, and the patient wishes to continue receiving uncovered care at the SNF, a SNFABN must be issued to the beneficiary.
- Delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs.

Notice of Medicare Non-Coverage (NOMNC/Generic Notice) – Billing

- A provider may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process, including a reconsideration by a Qualified Independent Contractor (QIC), if applicable, is complete.

Notice of Medicare Non- Coverage Survey Implications



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

SNF Beneficiary Notification Review

(Part A terminated/denied or resident was discharged)

How was the Medicare Part A Service Termination/Discharge determined?

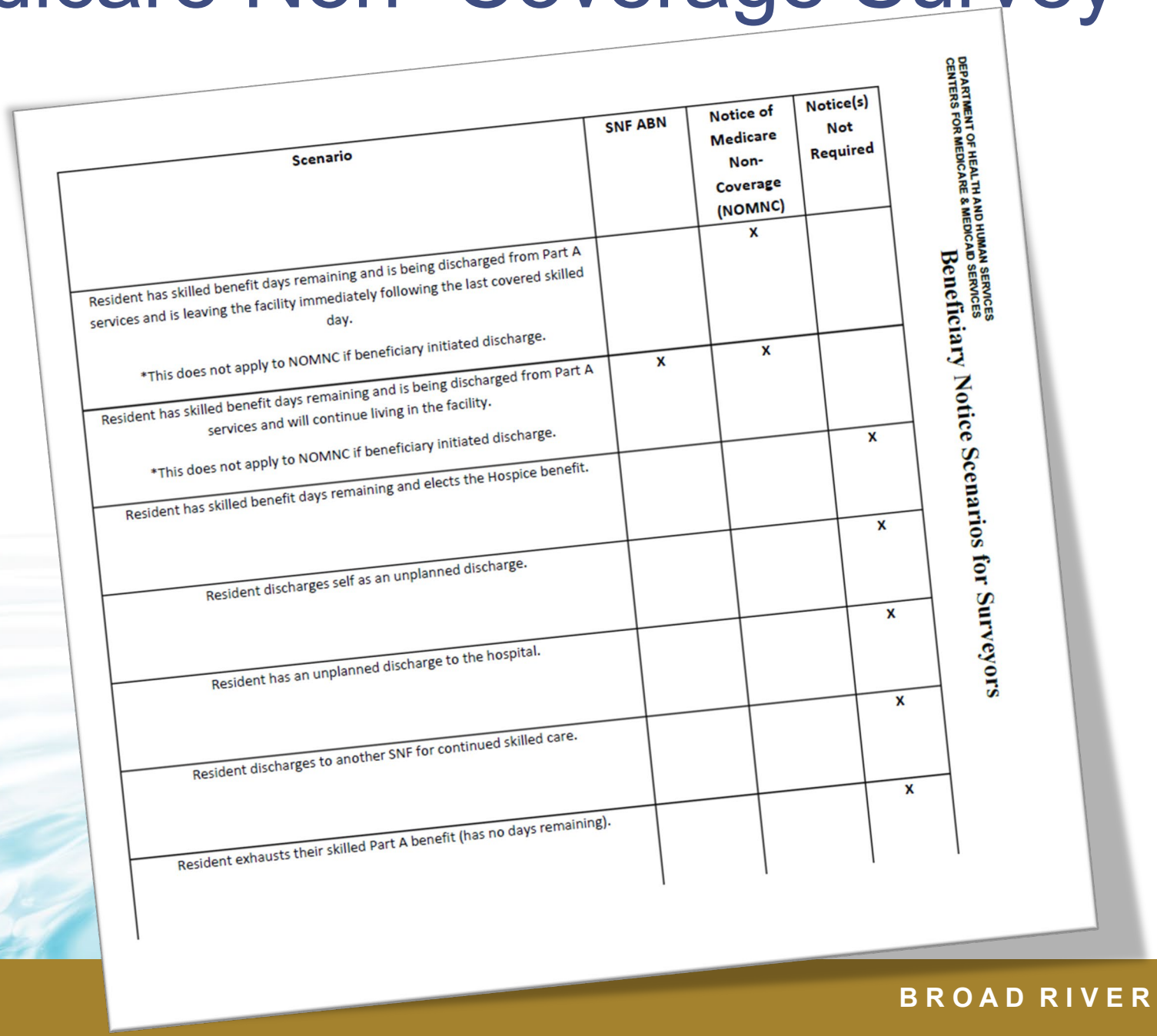
☐ Voluntary, i.e., self-initiated in consultation with physician, family, or AMA.

☐ The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.

☐ Other (explain):

1. Was a SNF ABN, Form CMS-10055 provided to the resident?	☐ Yes →If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative. ☐ No →If no, explain why the form was not provided: ☐ The resident was discharged from the facility and did not receive non-covered services. ☐ Other Explain: ☐ ***If NOT issued and should have been:** *cite* **F582**
2. Was a NOMNC, *Form* CMS-10123 provided to the resident?	☐ Yes→ If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative. ☐ No → If no, explain why the form was not provided: ☐ 1. The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, & discharged in the same day; Resident discharged AMA). ☐ 2. Other Explain: ☐ ***If NOT issued and should have been:** *cite* **F582**

Notice of Medicare Non- Coverage Survey Implications



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Beneficiary Notice Scenarios for Surveyors

Scenario	SNF ABN	Notice of Medicare Non-Coverage (NOMNC)	Notice(s) Not Required
Resident has skilled benefit days remaining and is being discharged from Part A services and is leaving the facility immediately following the last covered skilled day. *This does not apply to NOMNC if beneficiary initiated discharge.		X	
Resident has skilled benefit days remaining and is being discharged from Part A services and will continue living in the facility. *This does not apply to NOMNC if beneficiary initiated discharge.	X	X	
Resident has skilled benefit days remaining and elects the Hospice benefit.			X
Resident discharges self as an unplanned discharge.			X
Resident has an unplanned discharge to the hospital.			X
Resident discharges to another SNF for continued skilled care.			X
Resident exhausts their skilled Part A benefit (has no days remaining).			X

What Next?

1. Don’t neglect these notices
2. Have process/policy and procedure in place and that appropriate individuals are trained on their appropriate administration
3. Incorporate accountability in QA or morning meeting or Part A/B Reviews
4. Be sure that you are using the appropriate form and that it is the most current version.
5. Complete the notices completely
6. Follow CMS’ guidelines
7. !!! Understand the communication requirements with the QIOs (Faxes only) and have staff trained and available to respond timely.

QUESTIONS?

Get Involved

Join Broad River Rehab Insiders: https://broadriverrehab.com/resources/

Sign up for our Blog: www.broadriverrehab.com

Ask Our Experts: https://www.broadriverrehab.com/expert/

Webinars/Training: Broad River Rehab Reflections are the third Thursday of each month. March 16th:Telemedicine/ practice and remote therapeutic monitoring.

Skilled Nursing Facility:

Beneficiary's Name: **Identification Number:**

Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on_____, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

Care:	Reason Medicare May Not Pay:	Estimated Cost:

WHAT TO DO NOW:

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

OPTIONS: Check only one box. We can't choose a box for you.

☐ **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

☐ **Option 2.** I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare won't be billed.**

☐ **Option 3.** I don't want the care listed above. I understand that I'm not responsible for paying, and **I can't appeal to see if Medicare would pay**.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY:** 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

Signature of Patient or 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.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

{Insert provider contact information here}
Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current **{insert type}** Services Will End: **{insert effective date}**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: {insert QIO name and toll-free number of QIO} to appeal, or if you have questions.

See page 2 of this notice for more information.

Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: {insert provider/plan toll-free telephone number}

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information _____

_____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date

SNF Beneficiary Notification Review

Beneficiary Notification Review: Complete the review for residents who received Medicare Part A Services. Medicare beneficiaries have specific rights and protections related to financial liability and the right to appeal a denial of Medicare services under the Medicare Program. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. This protocol is intended to evaluate a nursing home's compliance with the requirements to notify Medicare beneficiaries when the provider determines that *Medicare Part A coverage is ending or when services may no longer be covered*. This review confirms that residents receive timely and specific notification when a facility determines that a resident no longer qualifies for Medicare **Part A** skilled services when the resident has not used all the Medicare benefit days for that episode. This review does not include Admission notifications or Medicare Part B only notifications.

The two forms of notification that are evaluated in this review are:

1. **Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN)—Form CMS-10055**; *and*
2. **Notice of Medicare Non-coverage *(NOMNC)* -- Form CMS-10123.**

Entrance Conference Worksheet: The following information was requested during the Entrance Conference:

☐ A list of Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months prior to the survey. Exclude the following residents from this review:

- Beneficiaries who received Medicare Part B benefits only.
- Beneficiaries covered under Medicare Advantage insurance.
- Beneficiaries who expired during the sample date range.
- Beneficiaries who were transferred to an acute care facility or another SNF.

Review Three Notices:

☐ Randomly select 3 residents from that list. We recommend selecting one resident who went home and two residents who remained in the facility, if available.

☐ Fill in the name of the selected residents at the top of each Beneficiary Notification Checklist.

☐ Give the provider one Beneficiary Notification Checklist for each of the three residents to complete and return to the surveyor.

☐ The provider completes one checklist for each of the three residents in this sample and returns the checklist and notices to the survey team.

☐ Review the checklists and notices with the provider.

1. Were appropriate notices given to the residents reviewed? ☐ Yes ☐ **No F582** ☐ NA

SNF Beneficiary Notification Review for Residents who Received Medicare Part A Services

Facility Representative: *Please complete* all fields of this form. The intent of the checklist is to provide the surveyor with all copies of the forms issued to the resident, and if the notification was not required, an explanation of why the form was not issued.

Resident Name: _____

Medicare Part A Skilled Services Episode Start Date: _____

Last covered day of Part A Service: _____

SNF Beneficiary Notification Review

(Part A terminated/denied or resident was discharged)

How was the Medicare Part A Service Termination/Discharge determined?

☐ Voluntary, i.e., self-initiated in consultation with physician, family, or AMA.

☐ The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.

☐ Other (explain):

1. Was a SNF ABN, Form CMS-10055 provided to the resident?	☐ Yes →If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative. ☐ No →If no, explain why the form was not provided: ☐ The resident was discharged from the facility and did not receive non-covered services. ☐ Other Explain: ☐ ***If NOT issued and should have been: *cite* F582**
2. Was a NOMNC, *Form* CMS-10123 provided to the resident?	☐ Yes→ If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative. ☐ No → If no, explain why the form was not provided: ☐ 1. The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, & discharged in the same day; Resident discharged AMA). ☐ 2. Other Explain: ☐ ***If NOT issued and should have been: *cite* F582**

Beneficiary Notice Scenarios for Surveyors

Scenario	SNF ABN	Notice of Medicare Non-Coverage (NOMNC)	Notice(s) Not Required
Resident has skilled benefit days remaining and is being discharged from Part A services and is leaving the facility immediately following the last covered skilled day. *This does not apply to NOMNC if beneficiary initiated discharge.		X	
Resident has skilled benefit days remaining and is being discharged from Part A services and will continue living in the facility. *This does not apply to NOMNC if beneficiary initiated discharge.	X	X	
Resident has skilled benefit days remaining and elects the Hospice benefit.			X
Resident discharges self as an unplanned discharge.			X
Resident has an unplanned discharge to the hospital.			X
Resident discharges to another SNF for continued skilled care.			X
Resident exhausts their skilled Part A benefit (has no days remaining).			X