<table>
<thead>
<tr>
<th>Situation</th>
<th>Form (click on links for forms)</th>
<th>Form Instructions (click on links for instructions)</th>
<th>Name of Form</th>
<th>General Purpose of Form</th>
<th>Required vs. Optional</th>
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<tbody>
<tr>
<td>Determination if Medicare is Primary Payer</td>
<td>CMS Pub 100-05 Transmittal 53 CR 5087 or an in-house compliant form (which has the same content and intent as the CMS model MSP)</td>
<td>Imbedded in the Questionnaire</td>
<td>Medicare as Secondary Payer Questionnaire Form (MSP)</td>
<td>Determines if Workers Comp, Black Lung, Group Health Plan, ESRD, or Disability is primary to Medicare</td>
<td>Optional, but Medicare will deny coverage if they are not primary. Questionnaire may be shortened for ease of use.</td>
</tr>
<tr>
<td>Initial, Reduction, or Termination Denial of Medicare Coverage. Do not used for technical denials.</td>
<td>ABN CMS 10055</td>
<td>Click Here</td>
<td>Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)</td>
<td>Inform new admission or new patient care situation that it is the facility’s opinion that Medicare will not cover for services provided.</td>
<td>Required, unless facility chooses to use one of the five approved denial letters as an alternate notice, but either the ABN or the appropriate letter must be issued.</td>
</tr>
<tr>
<td>Therapy Cap has been reached and therapy exceptions process (medically reasonable and necessary) is not applicable but therapy will be continued</td>
<td>ABN CMS 10055</td>
<td>Click Here for CMS Memo</td>
<td>Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)</td>
<td>Inform therapy patients that they have met their therapy cap, further therapies are not medically reasonable and necessary, and that Medicare will not cover further therapy services.</td>
<td>Required, unless facility chooses to use the ABN notice as an alternate notice, but either the appropriate letter or the ABN must be issued.</td>
</tr>
<tr>
<td>Initial, Reduction, or Termination Denial of Medicare Coverage. Do not used for technical denials.</td>
<td>No form numbers, only 5 versions of CMS approved form letters</td>
<td>Not Found</td>
<td>SNF Determination on Admission or UR Committee Determination on Admission</td>
<td>Inform new admission or new patient care situation that it is the facility’s opinion that Medicare will not cover for services provided.</td>
<td>Required, unless facility chooses to use the ABN notice as an alternate notice, but either the appropriate letter or the ABN must be issued.</td>
</tr>
<tr>
<td>Items or Services Are Not Covered by Medicare. May be used for technical denials, but not required.</td>
<td>CMS 20014</td>
<td>Not Found</td>
<td>Notice of Exclusions from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF)</td>
<td>Help clients make an informed choice about whether to receive the items/services knowing they may need to pay for them.</td>
<td>Optional</td>
</tr>
<tr>
<td>End of Medicare Coverage or Benefits</td>
<td>No form numbers, only 5 versions of CMS approved form letters</td>
<td>Not Found</td>
<td>SNF Determination on Continued Stay or UR Committee Determination on Continued Stay</td>
<td>When services furnished no longer qualify for payment by Medicare</td>
<td>Required, unless facility chooses to use the ABN notice, but either the ABN or the appropriate letter must be issued.</td>
</tr>
<tr>
<td>Expedited Appeal used after a period of Medicare coverage has ended or is being discontinued.</td>
<td>CMS 10123</td>
<td>Click Here for Instructions for detailed Instructions</td>
<td>Notice of Medicare Provider Non-Coverage – Expedited Appeal</td>
<td>To be provided not later than two days before the discontinuation of Medicare coverage – permits a quick coverage appeal to the BFCC-QIO (KEPRO)</td>
<td>Required</td>
</tr>
<tr>
<td>To be provided to the beneficiary by the provider in situations where an expedited appeal has been requested by the beneficiary</td>
<td>CMS 10124</td>
<td>Click Here for Instructions for detailed Instructions</td>
<td>Detailed Explanation of Non-Coverage</td>
<td>Provide a quick summary of why services are no longer covered by Medicare</td>
<td>Required to be completed by the end of the day by the provider upon receipt of the BFCC-QIO’s (KEPRO) notification to the facility of an expedited determination appeal.</td>
</tr>
<tr>
<td>SNF items/services expected to be denied under Medicare PART B</td>
<td>CMS-R-131</td>
<td>Click Here</td>
<td>Advance Beneficiary Notice of Noncoverage (ABN)</td>
<td>Provide a beneficiary advance notice of non-coverage for a Medicare Part B service or item while in a SNF.</td>
<td>Required, if Medicare Part B items or services are being provided and anticipated to be denied for coverage.</td>
</tr>
</tbody>
</table>
Key Concepts Regarding Liability Notices and Resident Appeal Rights

- The SNF provider may use either the SNFABN (CMS 10555) or one of the Denial Letters (from CMS’ website) for Medicare skilled services, except in circumstances of a technical denial. Form NFMB-SNF (CMS 20014) is an optional form that may be used for technical denials.

- A SNF does not have to use the SNFABN form (CMS 10055) or Denial Letter printed from the CMS website, but can place all the required information from the CMS 10055 or Denial Letter on the facility’s letterhead.

- The SNF provider is not required to issue a SNFABN (CMS 10055) or Denial Letter when SNF services are reduced or terminated in accordance with a physician’s order.

- When a beneficiary is receiving more than one skilled service (i.e., PT, OT, SP) and one, but not all the skilled services are being discontinued in accordance with the plan of care/doctor’s order, the SNF provider would not be required to issue the SNFABN (CMS 10055) or one of the Denial Letters. If all skilled services are ending with benefit days remaining, the SNF provider must issue the Generic notice (CMS 10123).

- The SNF provider is required to notify the beneficiary of the decision to terminate covered services (Combined Generic Notice, CMS 10123) no later than 2 days before the proposed end of the services.

- Residents or their legal representative must sign notices to verify receipt; however, if the resident is unable to receive the notice and the resident’s legal representative is unavailable, the SNF provider may contact the legal representative and inform him/her by phone. The SNF provider must immediately follow up the phone notification with a written notice. The date of telephone contact is considered to be the date the telephone notice was given as long as it is not disputed by the beneficiary.

- In requesting a list of Medicare beneficiaries discharged from the SNF, “discharge” refers to the termination of all Medicare skilled services. The facility is required to issue the Generic Notice (CMS 100123) prior to the complete cessation of all Medicare skilled services regardless of whether or not the resident is physically leaving the facility (i.e., remaining in the facility as a Medicaid or private pay resident.)

- In the context of surveying for liability notices and resident appeal rights, “non-covered stay” refers to Medicare skilled coverage.

- In the context of surveying for liability notices and resident appeal rights, “closed record” refers to Medicare skilled facility record.

- When all Medicare skilled covered services are ending, the facility must issue the Generic notice (CMS 10123) at least two days in advance of the service termination. If the resident requests an expedited review, the facility must issue a Detailed Notice of Provider Noncoverage (CMS Form 10124), which explains why it believes the resident’s coverage is ending. If the resident is receiving Medicare skilled care and has Medicare
KEY TERMS

ABN refers to an **Advanced Beneficiary Notice** (CMS Form R-131) and is used with Medicare Part B services when an item or service is expected to be denied by Medicare on a particular occasion as either not reasonable and necessary or because it constitutes custodial care.

**Beneficiary Notices Initiative Website** or **BNI Website** is located at www.cms.hhs.gov/bni. The BNI website provides information on financial liability notices, including the Revised ABN, SNFABN and SNF Denial Letters, Expedited Determination Notices and NEMB-SNF, and provides instruction for issuing each type of notice.

BFCC-QIO refers to a **Beneficiary and Family Centered Care Quality Improvement Organization**. BFCC-QIOs are independent reviewers that perform expedited reviews and quality of care reviews. Effective August 1, 2014, KEPRO is the BVCC-QIO for Minnesota. This function was previously provided by Stratis.

**Demand Bill** is a type of claim submitted by facility at the beneficiary’s request, which is medically reviewed by the FI. The SNFABN and the Denial Letters inform the beneficiary of potential liability for noncovered items or services, appeal rights, and of his/her right to have a claim (i.e., demand bill) submitted to Medicare.

**Denial Letter** is used interchangeably with SNFABN for Part A services. There are five uniform denial letters that providers may use.

**Detailed Notice of Non-Coverage**, known simply as the “**Detailed Notice**” or CMS Form 10124, explains to the beneficiary why the SNF believes services are no longer covered. This notice is only delivered to beneficiaries who requested an expedited appeal by a QIO.

**Expedited Appeal** refers to the right of fee-for-service beneficiaries to obtain a fast appeal by a QIO within 72 hours if the beneficiary disagrees with his/her discharge from provider services.

**Fiscal Intermediary** or **FI** adjudicates standard Medicare Part A claim appeals submitted to Medicare for care that has been furnished to the beneficiary.

“**Generic Notice**” is the **Combined Notice of Medicare Provider Non-Coverage** and is associated with CMS Form 10123. The Generic Notice informs beneficiaries that their Medicare covered services in a SNF are coming to an end. It also informs beneficiaries of their right to an expedited review by a QIO, if they feel they are being discharged too soon.

**Medicare Administrative Contract** or **MAC** adjudicates Medicare Part B standard claim appeals submitted to Medicare for care that has been furnished to the beneficiary.

**NEMB-SNF** or **Notice of Exclusion from Medicare Benefits** is used when notice is not required under either Medicare Parts A or B. NEMB-SNF is a voluntary notice used when an item/service is expected to be denied as a benefit category denial, meaning Medicare never covers it or it doesn’t meet the technical eligibility requirements for coverage such as the 3-day stay requirement has not been met.
The **Combined Notice of Medicare Provider Non-Coverage** is sometimes referred to as an **Expedited Determination Notice** or “Generic Notice” and is associated with CMS Form 10123. This notice informs beneficiaries that their Medicare covered services in a SNF are coming to an end. It also informs beneficiaries of their right to an expedited review by a QIO, if the beneficiary feels he/she is being discharged too soon.

**Quality Indicator Survey**, known as **QIS**, is a revised long-term care survey process that is currently the survey process in 11 states and will used all across the country.

**Revised ABN** is used for Part B services.

**SNFABN** refers to a **Skilled Nursing Facility Advanced Beneficiary Notice** and is associated with CMS Form 10055. This notice is used for Medicare Part A services only.

**Technical Denials** include circumstances such as:
- No qualifying 3-day inpatient hospital stay
- No Medicare days left in the benefit period
- Care is not ordered or certified by a physician
- Daily skilled care is not needed
- SNF transfer requirements are not met
- Resident does not have Medicare coverage