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**INFORMATIONAL LETTER #2009-1**

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**DATE:** January 30, 2009

**TO:** ALL IDAHO SKILLED NURSING FACILITIES/NURSING FACILITIES (SNF/NF'S)

**FROM:** DEBBY RANSOM, R.N., R.H.I.T., Chief  
Bureau of Facility Standards

**SUBJECT:** **CMS S&C-09-20 DATED 1/9/2009 ~ SURVEY AND CERTIFICATION  
ISSUES RELATED TO LIABILITY NOTICES AND BENEFICIARY  
APPEAL RIGHTS IN NURSING HOMES**

The Survey and Certification Letter listed above was released by CMS on January 9, 2009.

This Survey and Certification Letter can be found at:

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-20.pdf>

If you have any questions, please contact Loretta Todd, R.N., or Lorene Kayser, L.S.W., Q.M.R.P., in our offices at 208/334-6626.

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DEBBY RANSOM, R.N., R.H.I.T., Chief  
Bureau of Facility Standards

DR/nm

c: Idaho Health Care Association  
Qualis

Center for Medicaid and State Operations/Survey and Certification Group

**Ref: S&C-09-20**

**DATE:** January 9, 2009

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Survey and Certification Issues Related to Liability Notices and Beneficiary Appeal Rights in Nursing Homes

**Memorandum Summary**

- This memorandum reviews a Skilled Nursing Facility (SNF) provider's obligations to issue Medicare beneficiary liability notices, a Medicare beneficiary's rights related to standard claim and expedited appeals; and the surveyor's responsibility to determine compliance with Medicare notice and billing requirements for determinations of non-coverage.
- The SNF provider must inform the beneficiary of potential liability for payment for non-covered services when limitation of liability applies.
- The SNF must provide a written notice to the Medicare beneficiary explaining his/her right to file an expedited appeal upon termination of all Medicare covered services.
- Appendix P of the SOM, Survey Protocol for Long Term Care Facilities, Part VII will be deleted. The information in this memo will be moved to Sub-Task 5C and a new section on Liability Notices and Beneficiary Appeal Rights will be created.
- This memo does not apply to beneficiaries with Medicare Advantage.

**Background:**

Historically, Denial Letters have been the standard liability notification forms issued to Medicare beneficiaries by SNF providers. In response to requests by SNF providers to consolidate the five Denial Letters, CMS released in 2002 an alternative notice called a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN). Both the Denial Letters and the SNFABN inform the beneficiary of potential liability for the non-covered services and of his/her right to file a standard claim appeal if the related claim<sup>1</sup> submitted by the facility at the beneficiary's request is denied.

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<sup>1</sup> These claims are often referred to as "demand bills."

**Discussion:**

If a SNF provider believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable and necessary<sup>2</sup>, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability<sup>3</sup> for payment for the non-covered services.

The SNF's responsibility to provide notice to the resident can be fulfilled by use of either the SNFABN (form CMS-10055) or one of the five uniform Denial Letters. As noted previously, the SNFABN and the Denial Letters also inform the beneficiary of his/her right to have a claim (i.e., demand bill) submitted to Medicare. The SNF must file a claim when requested by the beneficiary.<sup>4</sup> The facility may not charge the resident for Medicare covered Part A services while the decision is pending.

**The Standard Claim Appeal Right/ SNFABN or a Denial Letter**

There are two types of appeals: the standard claim appeal and the expedited appeal. The standard claim appeal is an appeal filed with and adjudicated by the Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC) once a claim is submitted to Medicare for care that has been furnished to the beneficiary. The SNF must notify the beneficiary that the claim has been submitted. Once a claim is submitted, the beneficiary will receive a Medicare Summary Notice (MSN) explaining Medicare's payment decision. This notice will also inform the beneficiary of his/her standard claim appeal right and how to pursue such an appeal. FIs/MACs have up to 60 days to issue a decision on a standard claim appeal.

If the SNF provides the beneficiary with either a SNFABN (form CMS-10055) or a Denial Letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the Notice to Medicare Provider Non-coverage (form CMS-10123) to a beneficiary only conveys notice to the beneficiary of his or her right to an expedited review of a service termination and does not fulfill the provider's obligation to advise the beneficiary of potential liability for payment. A provider must still issue the SNFABN or a Denial letter to address liability for payment.

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<sup>2</sup> The limitation of liability provisions apply when a provider believes that an otherwise covered item or service may be denied as either not reasonable and necessary or constitutes custodial care under §1862(a)(1) or (a)(9) of the Social Security Act.

<sup>3</sup> More information about limitation of liability provisions can be found at §1879 of the Social Security Act.

<sup>4</sup> In general, Medicare claims must be filed within one full calendar year following the year in which the services were provided. For more information refer to 42 C.F.R. § 424.44 and the Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, section 70.1.

### **Expedited Appeal Rights/ Notice of Medicare Provider Non-coverage**

The second type of appeal is an expedited or “fast” appeal to the Quality Improvement Organization (QIO), which the QIO adjudicates within 72 hours. The Notice of Medicare Provider Non-coverage (form CMS-10123) informs the beneficiary of his/her right to an expedited review of a service termination. The Notice to Medicare Provider Non-coverage is sometimes referred to as an “Expedited Appeal Notice” or a “Generic Notice.”

The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. The SNF should not issue this notice if the beneficiary exhausts the Medicare covered days as the number of SNF benefit days is set in law and the QIO cannot extend the benefit period. Thus, a service termination due to the exhaustion of benefits is not considered a termination for “coverage” reasons.

### **Liability Notices/ Notice of Medicare Provider Non-coverage**

The Notice of Medicare Provider Non-coverage (form CMS-10123) is issued when all covered services end for coverage reasons. If after issuing the Notice of Medicare Provider Non-coverage, the SNF expects the beneficiary to remain in the facility in a non-covered stay, either the SNFABN (form CMS-10055) or a Denial Letter must be issued to inform the beneficiary of potential liability for the non-covered stay.

**Note:** If the beneficiary requests a QIO review, the SNFABN or a Denial Letter is not issued until after the QIO has determined that discontinuation of coverage is appropriate. When a QIO notifies a provider that a beneficiary has requested an expedited determination, the provider must send a Detailed Notice (CMS 10124) to the beneficiary by close of business of the day of the QIO’s notification.

In most cases when all covered services end for coverage reasons, a SNF provider will issue:

- Notice of Medicare Provider Non-coverage and a Denial Letter; or
- Notice of Medicare Provider Non-coverage and the SNF-ABN; or only
- The Notice of Medicare Provider Non-coverage.

In cases where all Medicare covered services are ending, the beneficiary is being discharged and is not requesting an expedited review, only the Notice of Medicare Provider Non-coverage is required. Additionally, there are rare instances where a SNF would issue only a Denial Letter or SNFABN. An example of this is when there is a reduction or termination in one Medicare Part A service while other Medicare Part A covered services are continuing.

Please see Attachment 1 for clarification on when the SNF provider must provide the beneficiary each type of notice.

**Surveying SNFs for Compliance with Notice Requirement**

Surveyors of SNFs were instructed in the State Operations Manual (SOM) that the SNF must use one of the Denial Letters found in §358 of the Skilled Nursing Facility Manual, and keep a copy of this notice on file. We will update the SOM to reflect the information in this memorandum, in particular, that the Denial Letters and the SNFABN (Form CMS-10055), are interchangeable and that issuing the Notice to Medicare Provider Non-coverage (Form CMS-10123) to a beneficiary does not fulfill the provider’s obligation to advise the beneficiary of the potential liability for payment.

Appendix P of the SOM, Survey Protocol for Long Term Care Facilities, Part VII, Additional Procedures for Medicare Participating Long Term Care Facilities will be deleted. The information in this memorandum will be moved to Sub-Task 5C and a new section: Liability Notices and Beneficiary Appeal Rights will be added. See Attachment 2 for details on how to survey for compliance with this requirement. The survey procedure in Attachment 2 is effective immediately and will serve as the current procedure until the SOM is updated to reflect this change.

**Effective Date:** This clarification is effective immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

**Training:** This policy should be shared with all survey and certification staff, their managers and the State/RO training coordinator. This policy should also be shared with all QIO staff and QIO and QIS training coordinators. This memo will be posted on the [QIONet](#) and [Beneficiary Notices Initiative](#) Web sites.

/s/  
Thomas E. Hamilton

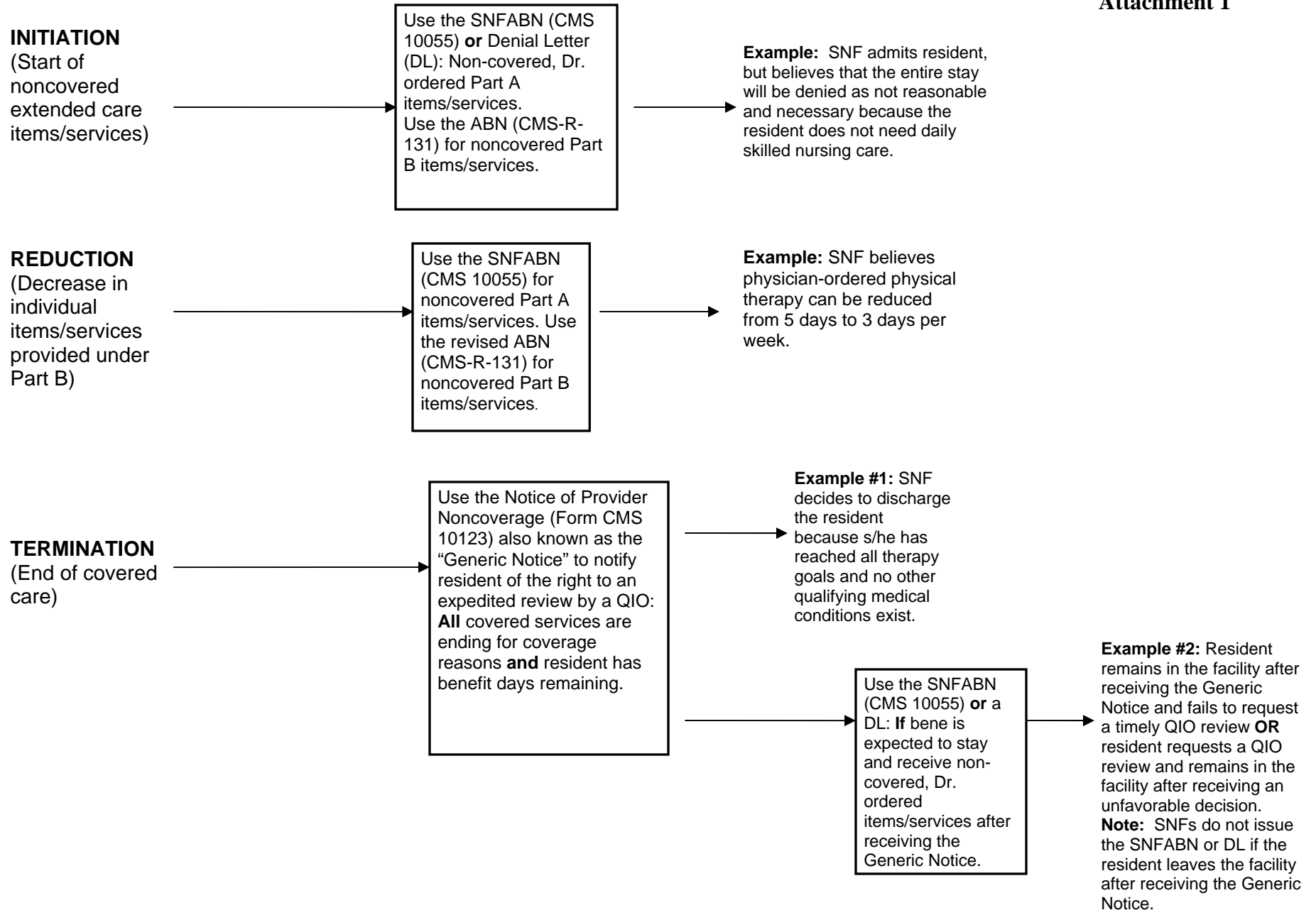
Attachment 1: Current SNF Notice Structure

Attachment 2: Survey Protocol for Compliance with Liability Notices and Beneficiary Appeal Rights

cc: Survey and Certification Regional Office Management  
QIO staff and training coordinators  
QIS staff and training coordinators

## Current SNF Notice Structure

### Attachment 1



The ABN-G (Form CMS-R-131) may be used for Part B items or services until February 28, 2009. Beginning March 1, 2009, the revised ABN must be used for Part B items or services.

**Survey Protocol for Compliance with Liability Notices and Beneficiary  
Appeal Rights**

**Sub-Task 5C—Resident Review**

**Liability Notices and Beneficiary Appeal Rights**

Medicare-participating long term care facilities are obligated to inform Medicare Part A and B beneficiaries about specific rights related to billing, and to submit bills to the Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC) when requested by the beneficiary. In a Medicare-participating long term care facility, verify compliance with these requirements.

Listed below are the requirements of the Skilled Nursing Facility (SNF).

1. If a SNF provider believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and that an otherwise covered item or service may be denied as not reasonable and necessary, the facility must notify the resident or his/her legal representative in writing and explain:
  - Why these specific services may not be covered;
  - The beneficiary's potential liability for payment for the non-covered services;
  - The beneficiary right to have a claim submitted to Medicare; and
  - The beneficiary's standard claim appeal rights that apply if the claim is denied by Medicare.

This notice requirement may be fulfilled by use of either the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) (CMS form 10055) or one of the five uniform Denial Letters found in §358 of the Skilled Nursing Facility Manual. The SNFABN and the Denial Letters inform the beneficiary of his/her right to have a claim submitted to Medicare and advises them of the standard claim appeal rights that apply if the claim is denied by Medicare. These claims are often referred to as "demand bills"<sup>1</sup> and are reviewed by FI or MAC.

The SNF:

- Must keep a copy of the SNFABN or Denial Notice on file;
- Must file a claim when requested by the beneficiary; and
- May not charge the resident for Medicare covered Part A services while a decision is pending.

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<sup>1</sup> See Ch. 1, §60.3 of the Medicare Claims Processing Manual for detailed instructions on submitting institutional demand bills.

2. The SNF must issue the Notice of Medicare Provider Non-coverage (CMS form 10123) when there is a termination of all Medicare Part A services for coverage reasons. The Notice of Medicare Provider Non-coverage informs the beneficiary of his/her right to an expedited review of a service termination by the Quality Improvement Organization (QIO). The Notice to Medicare Provider Non-coverage is sometimes referred to as an “Expedited Appeal Notice” or a “Generic Notice.” The SNF should not issue this notice if the beneficiary exhausts the Medicare covered days as the number of SNF benefit days is set in law and the QIO cannot extend the benefit period. Thus, a service termination due to the exhaustion of benefits is not considered a termination for “coverage” reasons.

The SNF:

- Must keep a copy of the Notice of Medicare Provider Non-coverage on file;
- Must file a claim when requested by the beneficiary; and
- May not charge the resident for Medicare covered Part A services while a decision is pending.

Failure to provide written liability of payment and/or appeal notice(s), to submit the bill (if requested by a resident), or to charge the resident for Medicare covered Part A services while a decision is pending may constitute a violation of the facility’s provider agreement. Refer to S&C-09-20 or go to <http://www.cms.hhs.gov/bni/> for more details about liability notices and resident appeal rights.

### Procedure to Determine Compliance

1. During the entrance conference, obtain a list of Medicare beneficiaries who requested demand bills in the past six months. From the list, randomly select one resident’s file to determine if the facility submitted the bill to the FI or MAC within the required timeframe. In general, Medicare claims must be filed within one full calendar year following the year in which the services were provided.<sup>2</sup> If the facility failed to submit the bill to the FI or MAC within the required timeframe or charged the resident while the decision was pending, the facility is in violation of the provider agreement with respect to resident billing requirements. Cite tag F492, 42 C.F.R. § 483.75(b), Compliance with Federal, State and local laws and professional standards and refer to 42 C.F.R. § 489.21, Specific limitations on charges.

**Note:** If no Medicare beneficiaries requested a demand bill in the past six months, this portion of the review is complete and the surveyor should continue with the closed record review.

2. During closed record review, review three charts of discharged Medicare beneficiaries from the SNF. If the current closed record review sample does not include three Medicare beneficiaries discharged from the SNF, expand the sample. Look for a copy of

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<sup>2</sup> For more information refer to 42 C.F.R. § 424.44 and the Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, section 70.1.



appropriate liability and appeal notice(s). If the facility failed to provide the resident the appropriate liability and/or appeal notice(s), the facility is in violation of the notice requirements. Cite tag F156, 42 C.F.R. 483.10, Resident rights.

If the record indicates the resident requested the facility submit the bill for appeal, determine if the facility submitted the bill to the FI or MAC within the required timeframe. In general, Medicare claims must be filed within one full calendar year following the year in which the services were provided.<sup>3</sup> If the facility failed to submit the bill to the FI or MAC within the required timeframe or charged the resident while the decision was pending, the facility is in violation of the provider agreement with respect to resident billing requirements. Cite tag F492, 42 C.F.R. § 483.75(b), Compliance with Federal, State and local laws and professional standards and refer to 42 C.F.R. § 489.21, Specific limitations on charges.

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<sup>3</sup> For more information refer to 42 C.F.R. § 424.44 and the Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, section 70.1.