

SNFABN Town Hall Meeting Questions & Answers

The following Qs & As represent the most commonly asked questions received by CMS leading up to, during, and following the SNFABN Town Hall meeting on September 26, 2006. Questions regarding any information contained in this document can be emailed to charlayne.van@cms.hhs.gov.

*The manual sections referenced below are part of CMS' Internet-Only Manual system and can be found by pressing the Ctrl button while clicking on the following link:
<http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf>*

Q1. When should the SNFABN, denial letters, expedited review and Notice of Exclusion from Medicare Benefits (NEMB) be issued?

A1. As indicated in our current instructions (Publication 100-4, Medicare Claims Processing Manual, Ch. 30, Section 70), the current SNFABN (Form 10055) or the Denial Letter must be issued to all fee-for-service beneficiaries at the initiation, reduction, or termination of all Part A items or services which a provider believes will not be covered because they are either not reasonable and necessary or constitute custodial care for which the beneficiary may be held financially liable. **Note: The draft SNFABN presented at CMS recent Town Hall meeting may not be used at this time.**

The ABN-G (Form CMS-R-131-G) must be issued to fee-for-service beneficiaries at the initiation, reduction, or termination of all Part B items or services, which a provider believes will not be covered because they are either not reasonable and necessary or constitute custodial care for which the beneficiary may be held financially liable. Under the proposed structure, the draft SNFABN would be issued in place of the ABN-G.

The expedited review notice or generic notice must be issued at the conclusion of all Medicare-covered care for either Parts A or B, when coverage is ending for coverage reasons only. For example, the SNF must provide an expedited notice when all covered services provided under Part A are terminated, but the beneficiary has remaining SNF days available and the beneficiary continues to stay in the facility. For guidance on expedited determination notice requirements, see 2005 CMS Transmittal 594, and the subsequent Questions and Answers on www.cms.hhs.gov/BNI, which have SNF-specific clarifications.

If Medicare is expected to deny payment for an item or service that is a Medicare benefit because it does not meet a technical benefit requirement (e.g. SNF transfer requirements not met), a SNFABN is not required. However, a Notice of Exclusion from Medicare Benefits (NEMB) may be

given voluntarily. Under the proposed structure, the draft SNFABN may also be given for this purpose.

- Q2. When would a provider be required to issue both the SNFABN and the expedited determination (generic) notice together?
- A2. The only time both notices would be necessary is when Medicare-covered care is ending and there is a physician's order supporting continued delivery of non-covered care. In this situation, the provider must issue the generic expedited determination notice to the beneficiary in order to advise him that Medicare coverage is ending and there is a right to an expedited appeal of the coverage determination. In addition, the SNF must give the SNFABN to the beneficiary prior to the initiation of the non-covered care.
- Q3. Is the SNFABN or any other notice required when there is a physician order to reduce or discontinue care?
- A3. No, a SNFABN would not be required, since non-covered care cannot be delivered without a physician's order and there would be no beneficiary liability. Currently, SNF's may voluntarily issue the NEMB. Under the proposed structure, the draft SNFABN may be given in a case where there is a physician's order to reduce or discontinue care.
- Q4. How would the SNF indicate on the SNFABN that notification was made by telephone or that the beneficiary refused to sign?
- A4. The date that corresponds with the signature of the staff person delivering the SNFABN serves as the date of telephone contact. The staff person can annotate the notice above the beneficiary's signature box that contact was made by telephone. Likewise, the staff person can indicate the beneficiary's refusal to sign the SNFABN in the beneficiary's signature box in accordance with Publication 100-4, Medicare Claims Processing Manual, Ch. 30, §40.3.4.6.
- Q5. It seems that the only option that would result in a bill to Medicare on the draft SNFABN would be Option 3; does that mean that every time that box is checked the claim submitted to Medicare would be a demand bill?
- A5. No, demand bills must be submitted, only when requested by the beneficiary for services determined to be either not medically necessary or not reasonable and necessary. Demand bills are not required for services that are statutorily excluded (i.e. beneficiary did not meet previous hospital stay requirements). Providers may submit statutorily excluded bills using a condition code 21 to indicate the provider is billing for denial. The beneficiary will be liable for these services.

- Q6. Does the draft SNFABN apply to beneficiaries enrolled in a Medicare Advantage plan?
- A6. No, both the current and the draft SNFABNs apply to only original Medicare or fee-for-service beneficiaries.
- Q7. How would the draft SNFABN be used for an item or service that Medicare never covers when the first sentence states, “Medicare is not likely to pay for the care described below”?
- A7. In this situation, the “Because” section on the draft SNFABN should clearly state that Medicare never covers the item or service listed in the “Items/Services” section. For example, “Medicare never covers a SNF stay when the transfer requirements have been not met”.
- Q8. Does the draft SNFABN give the beneficiary the option of not having a bill submitted to Medicare, but allowing a bill to be submitted to other insurance?
- A8. Yes, Option 3 allows the beneficiary to have a claim submitted to either Medicare and/or any other insurance. However, by choosing Option 3, the beneficiary agrees to be personally responsible for payment if neither Medicare nor any other insurance ultimately makes payment on the claim.
- Q9. In the estimated cost box, are SNFs required to include the actual cost of the purportedly denied item/service?
- A9. No, SNFs are only required to provide the estimated cost of the noncovered item/service. For example, an average daily cost can be used to estimate the cost when the beneficiary’s stay in the facility is no longer covered.
- Q10. As part of finalizing the draft SNFABN, is CMS considering consolidating the SNFABN with the expedited (generic) notice, or allowing swingbeds, not only SNFs to use these notices?
- A10. Yes, CMS is considering both of these options in addition to other possibilities.
- Q11. Are the draft abbreviated instructions the only instructions that will be released with the new SNFABN?
- A11. No, CMS will also release a new version of the current manual instructions found in Pub. 100-4, Medicare Claims Processing Manual, Ch. 30, §70 when the draft SNFABN is finalized for use.

Q12. When does CMS anticipate finalizing the draft SNFABN?

A12. Following the 30-day post Town Hall comment period, which ended November 3, 2006, CMS will complete the evaluation of all comments and begin finalizing both the notice and instructions. CMS anticipates implementing the final notice and instructions in the Spring of 2007.