

Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018)

Overview

These abbreviated instructions explain when and how the SNFABN must be delivered. Please also refer to the Medicare Claims Processing Manual, Chapter 30 for general notice requirements and detailed information on the SNFABN. Information on the ABN (Form CMS-R-131) can be found on the ABN webpage: <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>

Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:

- not medically reasonable and necessary; or
- considered custodial.

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). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services.

Completing the SNFABN

The SNFABN is available for download by selecting the “FFS SNFABN” link from the menu on the webpage <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html>. The SNFABN is a CMS-approved model notice and should be replicated as closely as possible when used as a mandatory notice. Failure to use this notice or significant alterations of the SNFABN could result in the notice being invalidated and/or the SNF being held liable for the care in question.

The SNFABN has the following 5 sections for completion:

1. Header
2. Body
3. Option Boxes
4. Additional Information
5. Signature and Date

Entries in the blanks may be typed or legibly hand-written and should be large enough for easy reading (approximately 12 point font).

1. **Header**

A. **SNF Information**

The first blank above the title “Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)” is labeled “Skilled Nursing Facility:” The SNF must include the SNF’s name, address, and phone number, at a minimum. A TTY number should be included when necessary to meet a beneficiary’s needs. Adding the SNF’s email address, additional contact information, and/or corporate logo is optional.

B. **Patient’s Name**

SNFs must enter the first and last name of the beneficiary receiving the notice, and a middle initial should be entered if there is one on the beneficiary’s Medicare card. The SNFABN will still be valid if there’s a misspelling or missing initial, as long as the beneficiary or their authorized representative recognizes the name listed on the notice.

C. **Identification Number**

Entering an identification number is optional, and the SNFABN is valid if this space is left blank. SNFs may insert an internal filing number (such as a medical record number) that might help link the notice with a related claim. Medicare numbers (i.e., Health Insurance Claim Numbers) or Social Security numbers **must not** be listed on the notice.

2. **Body**

A. **“Beginning On” Blank/ Effective Date of Potential Non-coverage**

In the blank that follows “Beginning on...,” the SNF enters the date on which the beneficiary may be responsible for paying for care that Medicare isn’t expected to cover.

B. **“Care” Section**

In this section, the SNF lists the care that it believes may not or won’t be covered by Medicare. The description must be written in plain language that the beneficiary can understand. The care can be listed as “inpatient stay at this facility,” for example.

C. **“Reason Medicare May Not Pay” Section**

The SNF must give the applicable Medicare coverage guideline(s) and a brief explanation of why the beneficiary’s medical needs or condition do not meet Medicare coverage guidelines. The reason must be sufficient and specific enough to enable the beneficiary to understand why Medicare may deny payment.

Below are examples of denial statements that explain some of the common reasons why an extended care stay or services may not be covered under Medicare. These denial statements are not mandatory language and can be modified to meet individual scenarios. The SNF may also develop language different from these examples to explain why an extended care stay, or services may not be paid for by Medicare.

Example 1: Beneficiary no longer requires skilled care but wants to continue residing in the SNF.

Care: Inpatient Skilled Nursing Facility Stay

Reason Medicare May Not Pay: 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.

Example 2: Beneficiary no longer requires daily skilled care but wants to continue residing in the SNF.

Care: Inpatient Skilled Nursing Facility Stay

Reason Medicare May Not Pay: You don't require skilled care on a daily basis. Medicare won't pay for your stay at this facility unless you need daily skilled care for your medical condition.

Example 3: Beneficiary no longer requires skilled therapy services and wants to continue residing in the SNF.

Care: Inpatient Skilled Nursing Facility Stay

Reason Medicare May Not Pay: You need help with repetitive exercises and walking, and you don't require skilled care. Medicare won't pay for your stay at this facility unless you need daily skilled care.

D. "Estimated Cost" Section

In this section, the SNF enters the estimated cost of the corresponding care that may not be covered by Medicare. The SNF should enter an estimated total cost or a daily, per item, or per service cost estimate. SNFs must make a good faith effort to insert a reasonable cost estimate for the care. The lack of a cost estimate entry on the SNFABN or an amount that is different than the final actual cost charged to the beneficiary does not invalidate the SNFABN.

If for some reason the SNF is unable to provide a good faith estimate of projected costs of care at the time of SNFABN delivery, the SNF should indicate in the cost estimate area that no cost estimate is available. This should not be a routine or frequent practice but allows timely issuance of the SNFABN during rare instances when a cost estimate is not available.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the SNFABN, in general. SNFs should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated a SNFABN.

3. Option Boxes

There are 3 options listed on the SNFABN with corresponding check boxes. The beneficiary must check only one option box. If the beneficiary is physically unable to make a selection, the SNF may enter the beneficiary's selection at his/her request and indicate on the notice that this was done for the beneficiary. Otherwise, SNFs are not permitted to select or pre-select an option for the beneficiary as this invalidates the notice.

Option 1:

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.

When the beneficiary selects Option 1, the care is provided, and the SNF must submit a claim to Medicare. The SNF must notify the beneficiary when the claim is submitted. This will result in a payment decision, and if Medicare denies payment, the decision can be appealed. SNFs aren't permitted to collect money for Part A services until Medicare makes an official payment decision on the claim.

Note: Beneficiaries who need an official Medicare decision (Medicare denial) for a secondary insurance claim should choose Option 1.

Option 2:

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.**

When the beneficiary selects Option 2, the care is provided, and the beneficiary pays for it out-of-pocket. The SNF does not submit a claim to Medicare. Since there is no Medicare claim, the beneficiary has no appeal rights.

Note: Although Option 2 indicates that Medicare will not be billed, SNFs must still adhere to the Medicare requirements for submitting no pay bills. See Chapter 6 of the Medicare Claims Processing manual for SNF claim submission guidance.

Option 3:

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.**

When the beneficiary selects Option 3, the care is not provided, and there is no charge to the beneficiary. Since no care is given, the SNF doesn't submit a claim, and there are no appeal rights.

4. Additional Information

SNFs may use this space to clarify and/or provide any additional information they think might be helpful to the beneficiary. For example, SNFs may use this space to include:

- information on other insurance coverage, such as a Medigap policy, if applicable;
- an additional dated witness signature; or
- other necessary notes.

Information in this section will be assumed to have been made on the same date the SNFABN is issued. If the notes are made on different dates, include those dates in the notes.

5. Signature and Date

The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF may fill in the date if the beneficiary needs help. This date should reflect the date that the SNF gave the notice to the beneficiary in-person, or when appropriate, the date contact was made with the beneficiary's authorized representative by phone. If an authorized representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the authorized representative's signature is not clearly legible, the authorized representative's name must be printed. If the beneficiary refuses to choose an option and/or refuses to sign the SNFABN when required, the SNF should annotate the original copy of the SNFABN indicating the refusal to sign and may list a witness to the refusal. The SNF should consider not furnishing the care.

Completing the SNFABN as a voluntary notice

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.

The following are examples of statements of non-coverage that can be inserted into the "Reason Medicare may not pay" section of the voluntary SNFABN.

Example 1

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;

- Medicare won't pay for your stay at this facility because more than 30 days have passed since your hospital discharge; or
- Medicare only pays for a certain number of days of inpatient care. You have used up all your days of inpatient care for this benefit period, and Medicare will no longer pay for your stay.

Example 2

Care: Barber services

Reason Medicare May Not Pay: Medicare never pays for barber or beauty services.

Example 3

Care: Routine foot care

Reason Medicare May Not Pay: Medicare never pays for routine foot care.