CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal: 12758	**Date: August 1, 2024**
	Change Request 13621

SUBJECT: Revisions to the Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-Coverage (ABN)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make minor revisions to the SNF ABN section in Chapter 30 (Financial Liability Protections) of Publication (Pub.) 100-04 (Medicare Claims Processing Manual).

EFFECTIVE DATE: October 2, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/TOC
R	30/70/Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN)
R	30/70/70.1/SNF ABN Standards
R	30/70/70.4/SNF ABN Specific Delivery Issues
R	30/120/120.5/120.5.1/Guide Paragraphs for Contractors to Use Where §1879 Is Applicable at Redetermination Level

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12758	Date: August 1, 2024	Change Request: 13621

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to make minor revisions to Chapter 30, Sections 70 and 120.5.1, in Pub. 100-04 (Medicare Claims Processing Manual). Also, there are revisions to the SNF ABN and the SNF ABN form instructions.

Section 1879 of the Social Security Act (the Act) (where the Limitation on liability provisions are located) requires a healthcare provider or supplier (i.e. notifier) to notify a beneficiary in advance of furnishing an item or service when s/he believes that items or services will likely be denied by Medicare for any of the reasons specified in the statutory provision in order to shift financial liability to the beneficiary for the denial. In the case of SNFs, advance notice is required if the item or service may be denied as not reasonable and necessary under §1862(a)(1) of the Act or because the item or service constitutes custodial care under §1862(a)(9) of the Act.

SNFs must also comply with the conditions of participation (42 Code of Federal Regulations (CFR) §483.10) regarding resident (beneficiary) rights.

B. Policy: §1879 and §§1862(a)(1) and (a)(9) of the Act and 42 CFR §483.10

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13621.1	Contractors shall accept a properly executed revised SNF ABN, Form CMS-10055, as valid notification beginning on the date of issuance of this CR. However, the mandatory date of use for SNFs to use this notice will be 30 days from issuance of this CR.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13621.2	Contractors shall review the process associated with the revised SNF ABN as indicated in the Pub. 100-04, Chapter 30, Section 70.	X								
13621.3	Contractors shall perform additional individual provider education if alerted that a notifier is not complying with these instructions.	X								

IV. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

Table of Contents
(Rev. 12758; Issued: 08-01-24)

Transmittals for Chapter 30

70 - Skilled Nursing Facility Advance Beneficiary Notice of Non-*Coverage (SNF ABN)*

70 - Skilled Nursing Facility Advance Beneficiary Notice of Non-*Coverage (SNF ABN)*

(Rev.: 12758; Issued: 08-01-24; Effective: 10-02-24; Implementation: 10-02-24)

The following are the standards for use by Skilled Nursing Facilities (SNFs) in implementing the SNF ABN (CMS-Approved Model Form CMS-10055) requirements. This section provides instructions, consistent with the SNF prospective payment system (SNF PPS), regarding the SNF ABN.

SNF ABN - Quick Glance Guide[3]

Notice Name: SNF ABN
Notice Number: CMS-Approved Model, Form CMS-10055
Issued by: SNFs for non-covered SNF PPS extended care items or services.
Recipient: Original Medicare fee-for-service (FFS) beneficiary

Additional Information:

The ABN, Form CMS-R-131 should be used for *Medicare* Part B non-covered items or services.

Type of Notice:	Must be issued in order to transfer liability to the beneficiary:	Timing of notice:	Optional/Voluntary use:
Financial liability notice	Before SNF PPS extended care items or services are furnished, reduced, or terminated when the SNF, the UR entity, the QIO, or the Medicare contractor believes that Medicare may not pay for, or will not continue to pay for, those extended care services on the basis of one of the following statutory exclusions: • Not reasonable and necessary ("medical necessity") for the diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member (§1862(a)(1) of the Act); or • Custodial care ("not a covered level of care") (§1862(a)(9) of the Act).	Prior to delivery of the care item or service in question. Provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.	Yes. It is recommended, but not necessary to transfer liability, for SNFs to issue prior to furnishing a care item or service that is never covered by Medicare (i.e. not a Medicare benefit).

[3] This is an abbreviated reference tool and is not meant to replace or supersede any of the directives contained in Section 70.

70.1 - SNF ABN Standards

(Rev.: 12758; Issued: 08-01-24; Effective: 10-02-24; Implementation: 10-02-24)

Step by step instructions for notice completion are posted along with the online replicable copies of the CMS-Approved Model, Form CMS-10055 on the CMS website. SNFs *should* not add any customizations to the notice beyond what is permitted by the accompanying SNF ABN form instructions and the guidelines published in this section. SNFs should follow the same standards when completing the SNF ABN as the ABN, Form CMS-R- 131 in §50.6 of this chapter, as applicable.

70.4 - SNF ABN Specific Delivery Issues

(Rev.: 12758; Issued: 08-01-24; Effective: 10-02-24; Implementation: 10-02-24)

When completing and delivering the SNF ABN, SNFs must meet the written notice standards

in *§50.6, 50.7 and 50.8* of this chapter, unless otherwise specified. Failure to provide a proper SNF ABN in situations where a physician has ordered the extended care item or service may result in the SNF being held financially liable under the LOL provisions, where such provisions apply. SNFs may also be sanctioned for violating the conditions of participation (42 CFR 483.10) regarding resident (beneficiary) rights.

NOTE: The SNF ABN is not a replacement for, but is in addition to, the required UR entity notices**.** The SNF ABN protects the SNF from liability in the event the beneficiary, for some reason, does not receive the UR entity notice.

120.5.1 - Guide Paragraphs for Contractors to Use Where §1879 Is Applicable at the Redetermination Level

(Rev.:12758; Issued: 08-01-24; Effective: 10-02-24; Implementation: 10-02-24)

The contractor uses the following paragraphs (in addition to other required appeal decision paragraphs) where the limitation on liability provision applies at the appeal level in the various situations shown below:

Situation I - To the provider, practitioner, or supplier when neither the provider, practitioner, or supplier nor the beneficiary is determined liable (program payment made under §1879 of the Act)

Paragraph(s):

Section 1879 of the Social Security Act permits Medicare payment to be made on behalf of a beneficiary to a physician/supplier who has accepted assignment for certain services for which payment would otherwise not be made under Medicare, if neither the beneficiary nor the physician/supplier knew, or could reasonably have been expected to know, that the services were excluded. The services affected by this provision are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. After reviewing (beneficiary's name's) claim for (description of services), we have concluded that these services are excluded under Medicare. However, since we find that neither (beneficiary's name) nor you knew, or could reasonably have been expected to know, that the services were excluded from coverage, the Medicare program will reimburse you under this provision of the law for the reasonable charge for the services, less any deductible and coinsurance. (Beneficiary's name) is responsible for any deductible and coinsurance amounts. Upon receipt of this notice, it will be considered that you now have knowledge of the exclusion of (description of service) for similar conditions, and this limitation of liability will not apply to future claims for the same or substantially similar services.

cc: Beneficiary

Situation II - To provider, practitioner, or supplier when the provider or practitioner or supplier is held liable

Paragraph(s);

Section 1879 of the Social Security Act permits Medicare payment to be made on behalf of a beneficiary to a provider or practitioner or supplier who has accepted assignment for certain services for which payment would otherwise not be made under Medicare.

Medicare may make payment under this situation if neither the beneficiary nor the provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the services were excluded. The services affected by this provision are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the

functioning of a malformed body member. After reviewing (beneficiary's name's) claim for (description of services), we have determined that (beneficiary's name) did not know and could not have been expected to know, that these services were excluded from coverage. However, we find that (select applicable phraseology from the following): (l) based upon the claim of (date) which was a similar claim in which payment was denied; (2) (our notification to you of (date) that such services are excluded); (3) (or any other basis used to determine the provider, practitioner, or supplier to be liable)), you knew, or could have been expected to know, that these services were excluded. We also find that you did not notify the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services. Because of this, you are held liable for the full charges for the services.

We have also reviewed the claim with regard to the issue of whether the services were not reasonable and necessary. We found that the services were not reasonable and necessary.

If you disagree with this determination regarding your liability, on the basis that the services were necessary, or on the basis that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services, or on the basis that you notified the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services, you may request a reconsideration within 180 days of receipt of this notice, at which time you may present any new evidence that

would have a material effect on this determination. Our office, or your social security office, will assist you if you need help in requesting a reconsideration.

cc: Beneficiary

Situation III - To the beneficiary when the beneficiary is held liable

Paragraph(s):

We have reviewed your claim for (description of the services). When we reviewed your claim, we considered two things. First, we considered whether the service you received was reasonable and necessary. Medicare will only pay for reasonable and necessary services. We found that the service was not reasonable and necessary.

Second, we considered whether you knew, or were told, that Medicare would not pay. Medicare would not hold you liable if you did not know and your (doctor/supplier) did not tell you in advance, in writing, that Medicare would not pay. Our review shows that (choose one of the following to complete the sentence: (the (doctor/ supplier) told you in writing, before giving the service, that Medicare would not pay); (this service had been denied on other claims for you); OR (we told you in a letter dated (DATE) that Medicare would not pay for this service)). Since we *have determined that* you knew Medicare would not pay for this service, you are liable for the charges. *(See, Section 1879 of the Social Security Act; 42 CFR 405.411)*

If you do not agree with our decision, ask for a reconsideration from a Qualified Independent Contractor (QIC). The QIC will decide whether the service was reasonable and necessary. The QIC will also decide whether you knew, or were told, Medicare would not pay. You must ask for a reconsideration within 180 days of the date you receive this notice. At the reconsideration, you may present any new evidence which would affect our decision. If you need help, your social security office will help you request a reconsideration.

cc: Physician/Supplier

Situation IV - Rider paragraph to be included in the copy of the notice to the beneficiary when the physician/supplier is held liable.

If you paid any amounts to (physician's/supplier's name) for this service, Medicare will pay you back the amount you paid. To get this payment, bring or send to this office three things. (1) A copy of this notice. (2) Your (doctor's/supplier's) bill. (3) A receipt or other proof you have paid the bill.

(See §§120.4 for handling requests for indemnification where payment has been made to a liable practitioner or supplier.)