

## SNF Beneficiary Protection Notification Review

**Beneficiary Protection Notification Review:** Complete the review for residents who received Medicare Part A Services. Medicare beneficiaries have specific rights and protections related to financial liability and the right to appeal a denial of Medicare services under the Fee for Service (Original) Medicare Program. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. The objective of the Beneficiary Liability Protection Notices Review is to determine if the facility issues notices as required under 42 CFR Part 405.1200-1204 and §1879(a)(1) of the Social Security Act. This protocol is intended to evaluate a nursing home's compliance with the requirements to notify Original (Fee-For-Service) Medicare beneficiaries when the provider determines that the beneficiary no longer meets the skilled care requirement. This review confirms that residents receive timely and specific notification when a facility determines that a resident no longer qualifies for Medicare **Part A** skilled services when the resident has not used all the Medicare benefit days for that episode. This review does not include Admission notifications or Medicare Part B only notifications.

The two forms of notification that are evaluated in this review are:

1. **Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)**—Form CMS-10055; or, the facility may instead use one of the 5 alternative denial letters, often incorrectly referred to as “cut letters”:
  - SNF Determination on Continued Stay—this would be an appropriate alternate letter to the SNF ABN.
  - UR Committee on Continued Stay—this would be an appropriate alternate letter to the SNF ABN.
  - Intermediary Determination of Non-coverage—this is basically the communication to the beneficiary of the result of the “demand bill” or request for redetermination. Provider wouldn't use this as an alternative to the SNF ABN for the initial determination.
  - UR Committee Determination of Admission—not surveying for this condition.
  - SNF Determination on Admission—again, not surveying for this condition.
2. **Notice of Medicare Non-coverage-- Form CMS 10123-NOMNC**, also referred to as a “generic notice.”

**Entrance Conference Worksheet:** The following information was requested during the Entrance Conference:

- A list of Original (Fee for Service) Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months prior to the survey. Exclude the following residents from this review:
- Beneficiaries who received Medicare Part B benefits only.
  - Beneficiaries covered under Medicare Advantage insurance.
  - Beneficiaries who expired during the sample date range.
  - Beneficiaries that were transferred to an acute care facility or another SNF.

### Review Three Notices:

- Randomly select 3 residents from that list. We recommend selecting one resident who went home and two residents who remained in the facility, if available.
- Fill in the name of the selected residents at the top of each Beneficiary Notification Checklist.
- Give the provider one Beneficiary Notification Checklist for each of the three residents to complete and return to the surveyor. Do not give the provider the scenarios.
- The provider completes one checklist for each of the three residents in this sample and returns the checklist and notices to the survey team.
- Review the checklists and notices with the provider.

1. Were appropriate notices given to the residents reviewed?  Yes  No F582  NA

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**SNF Beneficiary Protection Notification Review for Residents who Received Medicare Part A Services**

**Facility Representative:** Please complete all fields of this form. The intent of the checklist is to provide the surveyor with all copies of the forms issued to the resident, and if the notification was not required, an explanation of why the form was not issued.

Resident Name: \_\_\_\_\_

Medicare Part A Skilled Services Episode Start Date: \_\_\_\_\_

Last covered day of Part A Service: \_\_\_\_\_  
(Part A terminated/denied or resident was discharged)

How was the Medicare Part A Service Termination/Discharge determined?

- Voluntary, i.e., self-initiated in consultation with physician, family, or AMA.
- The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.
- Other (explain):

1. Was an SNF ABN, Form CMS-10055 or any of the 5 alternate denial notices provided to the resident?

- Yes → If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative.
- No → If no, explain why the form was not provided:
  - The resident was discharged from the facility and did not receive non-covered services.
  - Other  
Explain:
- \*If NOT issued and should have been: F582**

2. Was a NOMNC (CMS 10123) provided to the resident?

- Yes → If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative.
- No → If no, explain why the form was not provided:
  - 1. The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, & discharged in the same day; Resident discharged AMA).
  - 2. Other  
Explain:
- \*If NOT issued and should have been: F582**

## SNF Beneficiary Protection Notification Review

# Beneficiary Liability Protection Notice Scenarios for Surveyors

Scenario	Denial Letter or ABN	Notice of Medicare Non-Coverage (NOMNC)	Notice(s) Not Required
Resident has skilled benefit days remaining <b>and</b> is being discharged from Part A services <b>and</b> is leaving the facility immediately following the last covered skilled day.		X	
Resident has skilled benefit days remaining <b>and</b> is being discharged from Part A services <b>and</b> will continue living in the facility.	X	X	
Resident has skilled benefit days remaining <b>and</b> elects the Hospice benefit, <b>but</b> the coverage criteria for dual eligibility for Part A skilled and Hospice are not met.	X	X	
Resident discharges self as an unplanned discharge.			X
Resident has an unplanned discharge to the hospital.			X
Resident discharges to another SNF for continued skilled care.			X
Resident exhausts their skilled Part A benefit (has no days remaining).			X