ECS Solutions
a division of HW&Co.

Toll Free 877 367.4926
Web www.hwco.com

Protect Your Revenue

Decrease Losses Through Better A/R Billing Operations

THCA Annual Convention
August 16, 2023

© 2023 HW&Co. All Rights Reserved

{Insert provider contact information here}
Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current **{insert type}** Services Will End: **{insert effective date}**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: {insert QIO name and toll-free number of QIO} to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information _____
_____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____
Signature of Patient or Representative Date

Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123

When to Deliver the NOMNC

A Medicare provider or health plan (Medicare Advantage plans and cost plans , collectively referred to as “plans”) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Note: The two day advance requirement is not a 48 hour requirement.

This notice fulfills the requirement at 42 CFR 405.1200(b)(1) and (2) and 42 CFR 422.624(b)(1) and (2). Additional guidance for Original Medicare and Medicare Advantage can be found, respectively, at Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual.

Plans only:
In situations where the decision to terminate covered services is not delegated to a provider by a health plan, but the provider is delivering the notice, the health plan must provide the service termination date to the provider at least two calendar days before Medicare covered services end.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

Electronic issuance of NOMNCs is not prohibited. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of electronic notice delivery.

Notice Delivery to Representatives

CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered.

The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the enrollee's medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the provider's mailing date.

Exceptions

The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

- When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).

- When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).

- When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).

- When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).

- When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).

- When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

- When a provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

Plans Only:

If a member requests coverage in the above situations, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage.

Alterations to the NOMNC

The NOMNC must remain two pages. The notice can be two sides of one page or one side of two separate pages, but **must not** be condensed to one page.

Providers may include their business logo and contact information on the top of the NOMNC. Text may not be moved from page 1 to page 2 to accommodate large logos, address headers, etc.

Providers may include information in the optional "Additional Information" section relevant to the beneficiary's situation.

Note: Including information normally included in the Detailed Explanation of Non-Coverage (DENC) in the "Additional Information" section does not satisfy the responsibility to deliver the DENC, if otherwise required.

Heading

Contact information: The name, address and telephone number of the provider that delivers the notice must appear above the title of the form. The provider's registered logo may be used.

Member number: Providers may fill in the beneficiary's/enrollee's unique medical record or other identification number. The beneficiary's/enrollee's HIC number must not be used.

THE EFFECTIVE DATE YOUR {INSERT TYPE} SERVICES WILL END: {Insert Effective Date}: Fill in the type of services ending, **{home health, skilled nursing, comprehensive outpatient rehabilitation services, or hospice}** and the actual date the service will end. Note that the date should be in no less than 12-point type. If handwritten, notice entries must be at least as large as 12- point type and legible.

YOUR RIGHT TO APPEAL THIS DECISION

Bullet # 1 not applicable

Bullet # 2 not applicable

Bullet # 3 not applicable

Bullet # 4 not applicable

Bullet # 5 not applicable

HOW TO ASK FOR AN IMMEDIATE APPEAL

Bullet # 1 not applicable

Bullet # 2 not applicable

Bullet # 3 not applicable

Bullet # 4 Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than12-point type.

Signature page:

Plan contact information (Plans only): The plan's name and contact information must be displayed here for the enrollee's use in case an expedited appeal is requested or in the event the enrollee or QIO seeks the plan's identification.

Optional: Additional information. This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as a

Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.

Signature line: The beneficiary/enrollee or the representative must sign this line.

Date: The beneficiary/enrollee or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-xxxx**. The time required to complete this information collection is estimated to average **15 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please

write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: {insert provider/plan toll-free telephone number}

Form CMS-10124-DENC (Approved 12/31/2011) OMB Approval No. 0938–0953

Form Instructions for the Detailed Explanation of Non-Coverage (DENC) CMS-10124

A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as “plans”) must deliver a completed copy of this notice to beneficiaries/enrollees receiving covered skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services upon notice from the Quality Improvement Organization (QIO) that the beneficiary/enrollee has appealed the termination of services in these settings. The DENC must be provided no later than close of business of the day of the QIO’s notification.

Alterations to the DENC

Providers may include their business logo and contact information on the top of the DENC. Text may not be moved to a second page to accommodate large logos, address headers, etc.

Heading

Insert contact information here: The name, address and telephone number of the provider or plan that delivers the notice must appear above the title of the form. The entity’s registered logo is not required, but may be used.

Date: Fill in the date the notice is generated by the provider or plan.

Patient Name: Fill in the beneficiary’s/enrollee’s first and last name.

Member number: Fill in the beneficiary’s/enrollee’s medical record or identification number. The beneficiary’s/enrollee’s HIC number must not be used.

{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice.

Bullet # 1 The facts used to make this decision: Fill in the patient specific information that describes the current functioning and progress of the beneficiary/enrollee with respect to the services being provided. Use full sentences, in plain English.

Bullet # 2 The detailed explanation of why the services are no longer covered. Fill in the detailed and specific reasons why services are either no longer reasonable or necessary for the beneficiary/enrollee or are no longer covered according to the

Medicare guidelines. Describe how the beneficiary/enrollee does not meet these guidelines.

Bullet # 3 (Plans only) The plan policy, provision, or rationale used in the decision if the notice is delivered to a health plan enrollee: Fill in the reasons services are no longer covered according to the plan's policy guidelines, if applicable. Describe how the enrollee does not meet these guidelines. If the plan relied exclusively on Medicare coverage guidelines, please explain that here.

If you would like a copy of the policy: If the plan has not provided the Medicare guidelines or policy used to decide the termination date, inform the beneficiary/enrollee how and where to obtain the policy. Provide a telephone number for beneficiaries/enrollees to get a copy of the relevant documents sent to the QIO.

Skilled Nursing Facility:

Beneficiary's Name: **Identification Number:**

Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on_____, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

Care:	Reason Medicare May Not Pay:	Estimated Cost:

WHAT TO DO NOW:

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

OPTIONS: Check only one box. We can't choose a box for you.

☐ **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.

☐ **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.**

☐ **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**.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY:** 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

Signature of Patient or Authorized Representative*	Date

* If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

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.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

Form Instructions
Advance Beneficiary Notice of Non-coverage (ABN)
OMB Approval Number: 0938-0566

Overview

The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. "Notifiers" include:

- Physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories);
- Hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A; and
- Home health agencies (HHAs) providing care under Part A or Part B.

All of the aforementioned healthcare providers and suppliers must complete the ABN as described below in order to transfer potential financial liability to the beneficiary, and deliver the notice prior to providing the items or services that are the subject of the notice.

Medicare inpatient hospitals and skilled nursing facilities (SNFs) use other approved notices for Part A items and services when notice is required in order to shift potential financial liability to the beneficiary; however, these facilities must use the ABN for Part B items and services.

The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain a copy of the ABN delivered to the beneficiary on file.

The ABN may also be used to provide notification of financial liability for items or services that Medicare never covers. When the ABN is used in this way, it is not necessary for the beneficiary to choose an option box or sign the notice.

ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. With the latest PRA submission, a minor change has been made to update the nondiscriminatory language.

Completing the Notice

ABNs may be downloaded from the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html . Instructions for completion of the form are set forth below:

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

There are 10 blanks for completion in this notice, labeled from (A) through (J). We recommend that notifiers remove the lettering labels from the blanks before issuing the ABN to beneficiaries. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The notifier must also insert the blank (D) header information into all of the blanks labeled (D) within the Option Box section, Blank (G). One of the check boxes in the Option Box section, Blank (G), must be selected by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

Header:

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

1. **Blank (A) Notifier(s):** Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre- printing, using a label or other means.

   If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for billing questions.

2. **Blank (B) Patient Name:** Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

3. **Blank (C) Identification Number:** Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may

be used. Medicare numbers (HICNs), Medicare beneficiary identifiers (MBIs), or Social Security numbers should not appear on the notice.

Body:

4. **Blank (D): The following descriptors may be used in the Blank (D) fields:**

   Item
   Service
   Laboratory test
   Test
   Procedure
   Care
   Equipment

   - The notifier must list the specific names of the items or services believed to be non-covered in the column directly under the header of Blank (D).
   - In the case of partial denials, notifiers must list in the column under Blank (D) the excess component(s) of the item or service for which denial is expected.
   - For repetitive or continuous non-covered care, notifiers must specify the frequency and/or duration of the item or service.
   - General descriptions of specifically grouped supplies are permitted in this column. For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
   - When a reduction in service occurs**,** notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of supplies; just writing "wound care supplies decreased" is insufficient.
   - Please note that there are a total of 7 Blank (D) fields that the notifier must complete on the ABN. Notifiers are encouraged to populate all of the Blank (D) fields in advance when a general descriptor such as "Item(s)/Service(s)" is used. All Blank (D) fields must be completed on the ABN in order for the notice to be considered valid.

5. **Blank (E) Reason Medicare May Not Pay:** In the column under this header, notifiers must explain, in beneficiary friendly language, why they believe the items or services listed in the column under Blank (D) may not be covered by Medicare. Three commonly used reasons for non-coverage are:

   "Medicare does not pay for this test for your condition."
   "Medicare does not pay for this test as often as this (denied as too frequent)."
   "Medicare does not pay for experimental or research use tests."

To be a valid ABN, there must be at least one reason applicable to each item or service listed in the column under Blank (D). The same reason for non-coverage may be applied to multiple items in Blank (D) when appropriate.

6. **Blank (F) Estimated Cost:** Notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially non-covered services.

   Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted.

   Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

7. **Blank (G) Options:** Blank (G) contains the following three options:

- **OPTION 1.** I want the (D)_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

  This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed.

Suppliers and providers who don't accept Medicare assignment may make modifications to Option 1 only as specified below under "**H. Additional Information**."

*** Special guidance for people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage) ONLY:**

Dually Eligible beneficiaries must be instructed to check **Option Box 1** on the ABN in order for a claim to be submitted for Medicare adjudication.

Strike through **Option Box 1** as provided below:

- **OPTION 1.** I want the (D)_____listed above. ~~You may ask to be paid now, but~~ I ~~also~~ want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). ~~I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN.~~ If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

  The provider cannot bill the dual eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal law affecting coverage and billing of dual eligible beneficiaries. If Medicare denies a claim where an ABN was needed in order to transfer financial liability to the beneficiary, the claim may be crossed over to Medicaid or submitted by the provider for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue a Remittance Advice based on this determination.

  Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in the following circumstances:

  - If the beneficiary has QMB coverage without full Medicaid coverage, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy.

  - If the beneficiary has full Medicaid coverage and Medicaid denies the claim (or will not pay because the provider does not participate in Medicaid), the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.

  Note: These instructions should only be used when the ABN is used to transfer potential financial liability to the beneficiary and not in voluntary instances. More information on dual eligible beneficiaries may be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

- **OPTION 2.** I want the (D)_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

  This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

- **OPTION 3**. I don't want the (D)_____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

  This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided*;* thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Unless otherwise instructed to do so according to the specific guidance provided in these instructions, the notifier must not decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option."

8. **Blank (H) Additional Information:** Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

   - A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
   - Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable;
   - An additional dated witness signature; or
   - Other necessary annotations.

   Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

***Special guidance for non-participating suppliers and providers (those who don't accept Medicare assignment) ONLY:**

Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: ~~If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.~~

This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished. Alternatively, the line can be hand-penned on an already printed ABN. The sentence should be stricken and can't be entirely concealed or deleted. There is no CMS requirement for suppliers or the beneficiary to place initials next to the stricken sentence or date the annotations when the notifier makes the changes to the ABN before issuing the notice to the beneficiary.

When this sentence is stricken, the supplier should include the following CMS-approved unassigned claim statement in the (H) Additional Information section:

"This supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge."

This statement can be included on ABNs printed for unassigned items and services, or it can be handwritten in a legible 10 point or larger font.

An ABN with the Option 1 sentence stricken must contain the CMS-approved unassigned claim statement as written above to be considered valid notice. Similarly, when the unassigned claim statement is included in the "Additional Information" section, the last sentence in Option 1 should be stricken.

Signature Box:

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

9. **Blank (I) Signature:** The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.

10. **Blank (J) Date:** The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statements in the footer of the notice are required to be included on the document.

CMS will work with its contractors to ensure consistency when determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

1 BEAR CAVE SNF
123 ANYWHERE ST
ANYPLACE OH 432221234

3a PAT CNTL #	000123456	4 TYPE OF BILL
b. MED. REC #	123456	213

5 FED TAX I.D.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
111222333	01/01/2023	01/31/2023	

8 PATIENT NAME		9 PATIENT ADDRESS				
b BEAR BOOBOO		b ANYPLACE		c OH	d 43222	e

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
06/29/1921	M	12/04/2022	09	3	4		30													

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
50	12/08/2022							70	12/01/2022	12/04/2022				

38 BOOBOO BEAR
123 ANYWHERE ST

ANYPLACE OH 43222

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	09	1.00	80	31.00	82	31.00
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPSCODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	JDFE1		14	0.00		
0022	SNF HIPPS RATE CODE	ZZZZZ		17	0.00		
0120	ROOM-BOARD/SEMI		01/01/2023	31	6200.00		
0250	PHARMACY			1	463.26		
0420	PHYSICAL THERAPY			25	3000.00		
0430	OCCUPATIONAL THERAPY			25	2900.00		
0001	PAGE 1 OF 1	CREATION DATE	02/15/2023	TOTALS	12563.26	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0001112223
WI MEDICARE		Y	Y			57 OTHER PRV ID	
MI BLUE CROSS	00210	Y	Y				

58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BEAR	BOOBOO	18	123Q456T789		
BEAR	BOOBOO	18	XYL123456789		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX										68
	S72142D	J9601	Z9181	S42202D	I4891	N1830	Z86718	F0390	I130	
0	E785	I739	I429	I361	I350	Z8673	G9340	I5032	N390	

69 ADMIT DX	S72142D	70 PATIENT REASON DX				71 PPS CODE		72 ECI			73	

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 0001112224	QUAL	
LAST SMITH		FIRST JOHN	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC a	B3	314000000X
PART A BENEFIT EXHAUST CLAIM	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 BEAR CAVE SNF
123 ANYWHERE ST
ANYPLACE OH 432221234

3a PAT CNTL #	000123456	4 TYPE OF BILL
b. MED. REC #	123456	213

5 FED TAX I.D.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
111222333	02/01/2023	02/28/2023	

8 PATIENT NAME		9 PATIENT ADDRESS				
b BEAR BOOBOO		b ANYPLACE		c OH	d 43222	e

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
06/29/1921	M	12/04/2022	09	3	4		30													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	12/01/2022	12/04/2022				

38 BOOBOO BEAR
123 ANYWHERE ST

ANYPLACE OH 43222

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	09	1.00	80	28.00	82	28.00
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	ZZZZZ		28	0.00		
0120	ROOM-BOARD/SEMI		02/01/2023	28	5600.00		
0250	PHARMACY			1	463.26		
0001	PAGE 1 OF 1	CREATION DATE	03/09/2023	TOTALS	6063.26	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0001112223
WI MEDICARE		Y	Y			57 OTHER PRV ID	
MI BLUE CROSS	00210	Y	Y				

58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BEAR	BOOBOO	18	123Q456T789		
BEAR	BOOBOO	18	XYL123456789		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX										68
	S72142D	J9601	Z9181	S42202D	I4891	N1830	Z86718	F0390	I130	
0	E785	I739	I429	I361	I350	Z8673	G9340	I5032	N390	

69 ADMIT DX	S72142D	70 PATIENT REASON DX				71 PPS CODE		72 ECI			73	

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	0001112224	QUAL	
LAST	SMITH	FIRST	JOHN	
77 OPERATING	NPI		QUAL	
LAST		FIRST		
78 OTHER	NPI		QUAL	
LAST		FIRST		
79 OTHER	NPI		QUAL	
LAST		FIRST		

80 REMARKS	81CC a		
PART A BENEFIT EXHAUST CLAIM		B3	314000000X
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 BEAR CAVE SNF
123 ANYWHERE ST
ANYPLACE OH 432221234

3a PAT CNTL #	000123456		4 TYPE OF BILL
b. MED. REC #	123456		213
5 FED TAX I.D.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
111222333	03/01/2023	03/04/2023	

8 PATIENT NAME		9 PATIENT ADDRESS	123 ANYWHERE ST		
b BEAR BOOBOO		b ANYPLACE	c OH	d 43222	e

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
06/29/1921	M	12/04/2022	09	3	4		30													

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
22	03/04/2023							70	12/01/2022	12/04/2022				

38 BOOBOO BEAR
123 ANYWHERE ST

ANYPLACE OH 43222

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	09	1.00	80	4.00	82	4.00
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPSCODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	ZZZZZ		4	0.00		
0120	ROOM-BOARD/SEMI		03/01/2023	4	800.00		
0250	PHARMACY			1	463.26		
0001	PAGE 1 OF 1	CREATION DATE	04/05/2023	TOTALS	1263.26	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0001112223
WI MEDICARE		Y	Y			57 OTHER PRV ID	
MI BLUE CROSS	00210	Y	Y				

58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BEAR	BOOBOO	18	123Q456T789		
BEAR	BOOBOO	18	XYL123456789		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX										68
0	S72142D	J9601	Z9181	S42202D	I4891	N1830	Z86718	F0390	I130	
	E785	I739	I429	I361	I350	Z8673	G9340	I5032	N390	

69 ADMIT DX S72142D | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 0001112224	QUAL	
LAST SMITH	FIRST JOHN		
77 OPERATING	NPI	QUAL	
LAST	FIRST		
78 OTHER	NPI	QUAL	
LAST	FIRST		
79 OTHER	NPI	QUAL	
LAST	FIRST		

80 REMARKS PART A CLAIM
BENEFIT EXHAUST SHOWING LOC

81CC			
a	B3	314000000X	
b			
c			
d			

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 BEAR CAVE SNF
123 ANYWHERE ST
ANYPLACE OH 432221234

3a PAT CNTL #	000123456	4 TYPE OF BILL	
b. MED. REC #	123456	210	
5 FED TAX I.D.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
111222333	03/05/2023	03/31/2023	

8 PATIENT NAME		9 PATIENT ADDRESS				
b BEAR BOOBOO		a 123 ANYWHERE ST				
		b ANYPLACE	c OH	d 43222	e	

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
06/29/1921	M	12/04/2022	09	3	4	09	30	21												

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
								70	12/01/2022	12/04/2022				

38 BOOBOO BEAR
123 ANYWHERE ST

ANYPLACE OH 43222

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	81	27.00				
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPSCODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	ZZZZZ		27	0.00		
0120	ROOM-BOARD/SEMI		03/01/2023	27	5400.00	5400.00	
0001	PAGE 1 OF 1	CREATION DATE	04/05/2023	TOTALS	5400.00	5400.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0001112223
WI MEDICARE		Y	Y			57 OTHER PRV ID	
MI BLUE CROSS	00210	Y	Y				

58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BEAR	BOOBOO	18	123Q456T789		
BEAR	BOOBOO	18	XYL123456789		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX										68
0	S72142D	J9601	Z9181	S42202D	I4891	N1830	Z86718	F0390	I130	
	E785	I739	I429	I361	I350	Z8673	G9340	I5032	N390	

69 ADMIT DX S72142D	70 PATIENT REASON DX				71 PPS CODE		72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 0001112224	QUAL	
LAST SMITH	FIRST JOHN		
77 OPERATING	NPI	QUAL	
LAST	FIRST		
78 OTHER	NPI	QUAL	
LAST	FIRST		
79 OTHER	NPI	QUAL	
LAST	FIRST		

80 REMARKS MEDICARE NO PAY
BENEFIT EXHAUST SHOWING LOC

81CC		
a	B3	314000000X
b		
c		
d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1	BEAR CAVE SNF 123 ANYWHERE ST ANYPLACE OH 432221234
3a PAT CNTL #	000123456
b. MED. REC #	123456
4 TYPE OF BILL	210
5 FED TAX I.D.	111222333
6 STATEMENT COVERS PERIOD FROM	03/05/2023
THROUGH	03/31/2023
8 PATIENT NAME	BEAR BOOBOO
9 PATIENT ADDRESS	123 ANYWHERE ST, ANYPLACE, OH 43222

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 CONDITION CODES
06/29/1921	M	12/04/2022	09	3	4	09	30	20

35 OCCURRENCE SPAN CODE	FROM	THROUGH
70	12/01/2022	12/04/2022

38
BOOBOO BEAR
123 ANYWHERE ST
ANYPLACE OH 43222

39 VALUE CODES CODE	AMOUNT
a 81	27.00

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0022	SNF HIPPS RATE CODE	ZZZZZ		27	0.00	
0120	ROOM-BOARD/SEMI		03/01/2023	27	5400.00	5400.00
0001	PAGE 1 OF 1	CREATION DATE	04/05/2023	TOTALS	5400.00	5400.00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
WI MEDICARE		Y	Y		
MI BLUE CROSS	00210	Y	Y		

56 NPI 0001112223

58 INSURED'S NAME		59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BEAR	BOOBOO	18	123Q456T789		
BEAR	BOOBOO	18	XYL123456789		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX								
S72142D	J9601	Z9181	S42202D	I4891	N1830	Z86718	F0390	I130
0 E785	I739	I429	I361	I350	Z8673	G9340	I5032	N390

69 ADMIT DX S72142D

76 ATTENDING NPI 0001112224 LAST SMITH FIRST JOHN

80 REMARKS DEMAND BILL

81CC a B3 314000000X

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 BEAR CAVE SNF
123 ANYWHERE ST
ANYPLACE OH 432221234

3a PAT CNTL #	000123456	4 TYPE OF BILL
b. MED. REC #	123456	214

5 FED TAX I.D.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
111222333	03/01/2023	03/15/2023	

8 PATIENT NAME		9 PATIENT ADDRESS				
a		a	123 ANYWHERE ST			
b BEAR BOOBOO		b ANYPLACE		c OH	d 43222	e

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
06/29/1921	M	12/04/2022	09	3	4	09	01	04												

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
50	12/08/2022													

38 BOOBOO BEAR
123 ANYWHERE ST

ANYPLACE OH 43222

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	09	2800.00	80	14.00	82	14.00
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPSCODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	ZZZZZ		14	0.00		
0120	ROOM-BOARD/SEMI		03/01/2023	14	5400.00		
0250	PHARMACY			1	324.76		
0420	PHYSICAL THERAPY			10	1500.00		
0001	PAGE 1 OF 1	CREATION DATE	04/05/2023	TOTALS	7224.76	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0001112223
WI MEDICARE		Y	Y			57 OTHER PRV ID	
MI BLUE CROSS	00210	Y	Y				

58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BEAR	BOOBOO	18	123Q456T789		
BEAR	BOOBOO	18	XYL123456789		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX										68
	S72142D	J9601	Z9181	S42202D	I4891	N1830	Z86718	F0390	I130	
0	E785	I739	I429	I361	I350	Z8673	G9340	I5032	N390	

69 ADMIT DX S72142D	70 PATIENT REASON DX				71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 0001112224	QUAL	
LAST SMITH	FIRST JOHN		
77 OPERATING	NPI	QUAL	
LAST	FIRST		
78 OTHER	NPI	QUAL	
LAST	FIRST		
79 OTHER	NPI	QUAL	
LAST	FIRST		

80 REMARKS MCR ADV NO PAY

81CC		
a	B3	314000000X
b		
c		
d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing

The SNF annual update file contains a comprehensive list of HCPCS codes involved in editing institutional claims submitted to A/B MACs for services subject to SNF consolidated billing (CB). The CMS has divided these codes into 5 Major Categories.

General explanation of the Categories:

Major Category I - Exclusion of Services Beyond the Scope of a SNF

These services must be provided on an outpatient basis at a hospital, including a critical access hospital (CAH) only, not by a SNF, and are excluded from SNF PPS and CB for beneficiaries in a Part A stay. Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are excluded from SNF CB, with exceptions as listed below.

- In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed as inclusions under Major Category I.F) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

NOTE: Services billed by providers to the Medicare Administrative Contractor represent the facility charge portion for those services.

Major Category I. is further broken down into subcategories:

A. Computerized Axial Tomography (CT) Scans
B. Cardiac Catheterization
C. Magnetic Resonance Imaging (MRIs)
D. Radiation Therapy
E. Angiography, Lymphatic, Venous and Related Procedures
F. Outpatient Surgery and Related Procedures– INCLUSION (see note below)

Note: Inclusions, rather than exclusions, are given in this one case, because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing minor procedures that can be performed in the SNF itself. The physician's service itself may be excluded for the codes listed (identified in the Carrier A/B MAC files) in this section, however, when these codes are billed by the hospital they are for the technical/facility charge and are not excluded.

G. Emergency Services

These services are identified on claims submitted to Part A MACs by a hospital or CAH using revenue code 045x (Emergency Room—"x" represents a varying third digit). Related services with the same line item date of service (LIDOS) are also excluded. Note that in order to get a match on the LIDOS there must be a LIDOS and HCPCS in revenue code 045x.

Note: In order to bypass services related to the ER encounter, which are performed on subsequent service dates, hospitals must identify those services by appending a modifier ET (Emergency Services) to those line items. Please review Change Request 5389 for further information.

H. Ambulance Trips – With Application to Major Category II

Note: Ambulance trips associated with Major Category I.A-E and G services are excluded from SNF CB. In addition, ambulance trips associated with Major Category II. A. services provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing.

I. Additional Surgery HCPCS – EXCLUSIONS

These services are additional surgery exclusions that do not fall within the Outpatient Surgery HCPCS codes ranges 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed as inclusions under Major Category I.F)

Major Category II - Additional Services Excluded when Rendered to Specific Beneficiaries

These services must be provided to specific beneficiaries, either: (A) End Stage Renal Disease (ESRD) beneficiaries, or (B) beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing. SNFs will not be paid for Category II.A. Services (dialysis, etc.) when the SNF is the place of service, as to receive Medicare payment, these services must be provided in a renal dialysis facility. Hospices must also be the only type of provider billing hospice services.

NOTE: This category also excludes non-ESRD acute dialysis from SNF CB, as set forth in §20.2.1 of the Medicare Claims Processing Manual, Chapter 6.

A. Dialysis, EPO, Aranesp, and Other Dialysis Related Services for ESRD Beneficiaries

Specific coding is used to differentiate dialysis and related services that are excluded from SNF consolidated billing for ESRD beneficiaries in three cases: (1) when the services are provided in a RDF (including ambulance services listed under Major Category I. above), (2) home dialysis when the SNF constitutes the home of the beneficiary, and (3) when the drugs EPO or Aranesp are used for ESRD beneficiaries. *Note that SNFs may not be paid for home dialysis supplies.*

1. Coding Applicable to Services Provided in a RDF or SNF as Home

Institutional dialysis services billed only by a RDF are identified by type of bill 72X. ESRD beneficiaries billed by an RDF must be accompanied by the dialysis related diagnosis code N18.6.

NOTE: The applicable HCPCS codes are identified in the excel file as Dialysis Supplies and Dialysis Equipment.

2. Coding Applicable to EPO and Aranesp Services

Epoetin alfa (trade name EPO) is a drug Medicare approved for use by ESRD beneficiaries.

Darbepoetin alfa (trade name Aranesp) is a drug Medicare approved for use by ESRD beneficiaries.

NOTE: When epoetin alfa or darbepoetin alfa are given by the dialysis facility in conjunction with dialysis, these drugs are exclude d and must be billed by the RDF. Instructions for billing RDF services are located in publication 100-4, chapter 8.

To distinguish epoetin alfa or darbepoetin alfa given to ESRD beneficiaries from the same drugs given to non-ESRD beneficiaries CMS has developed separate codes. The instructions for billing for non-ESRD epoetin alfa or darbepoetin alfa are located in publication 100-4, chapter 17, section 80.9.

NOTE: These drugs for non-ESRD use are always bundled to the SNF for beneficiaries in a covered Part A stay.

B. Hospice Care for a Beneficiary's Terminal Illness

Hospice services for terminal conditions are identified with the following bill types: 81X or 82X.

Major Category III - Additional Excluded Services Rendered by Certified Providers

These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing.

HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes and customized prosthetic devices are set in statute. This statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories; accordingly, the minor and conforming changes in coding that appear in the instruction are made under that authority.

A. Chemotherapy
B. Chemotherapy Administration

Note : Chemotherapy Administration codes listed with an asterisk (*) in the file are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services and physician orders must exist to support the provision of chemotherapy. Codes listed w/o an asterisk (*) are treated the same as those with an (*) for all providers except hospitals, including CAHs. Codes w/o an (*) are excluded surgery codes and may be billed w/o a chemotherapy agent in hospital settings only

C. Radioisotopes and their Administration
D. Customized Prosthetic Devices
E. Certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders, and items and services related to the furnishing of such factors.

Major Category IV - Additional Excluded Preventive and Screening Services

These services are covered as Part B benefits and are not included in SNF PPS. Such services must be billed by the SNF for beneficiaries in a Part A stay with Part B eligibility on type of bill (TOB) 22X. Swing Bed providers must use TOB 12X for eligible beneficiaries in a Part A SNF level.

Note: Please access Chapter 18 "Preventive and Screening Services" of the Claims Processing manual for coverage and billing guidance.

A. Mammography
B. Vaccines (Pneumococcal, Flu, Hepatitis B, or Covid-19)
C. Vaccine Administration
D. Screening Pap Smear and Pelvic Exams
E. Colorectal Screening Services
F. Prostate Cancer Screening
G. Glaucoma Screening
H. Diabetic Screening
I. Cardiovascular Screening
J. Initial Preventative Physical Exam
K. Abdominal Aortic Aneurysms (AAA) Screening

Major Category V - Part B Services Included in SNF Consolidated Billing

Therapy services are included in SNF PPS and consolidated billing for residents in a Part A stay, and must be billed by the SNF alone for its Part B residents.

A. Therapies billed with revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)