Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN)
Form CMS-10055 (2024)

Overview

These abbreviated instructions explain when and how the SNF ABN must be delivered. Please also refer to the Medicare Claims Processing Manual, Chapter 30, Section 70 for general notice requirements and detailed information on the SNF ABN. 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 Skilled Nursing Facilities (SNFs) to issue the SNF ABN to Original Medicare, also called fee-for-service (FFS), patients 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 SNF ABN provides information to the patient 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 SNF ABN when applicable for SNF Prospective Payment System services (Medicare Part A). It is important to note that **the SNF ABN, CMS-10055, is only issued if the beneficiary intends to continue services** and the SNF believes the services may not be covered under Medicare. SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services.

Completing the SNF ABN

The SNF ABN is available for download on the FFS SNF ABN webpage:
https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-snf-abn
The SNF ABN 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 SNF ABN could result in the notice being invalidated and/or the SNF being held liable for the care in question.

The SNF ABN has the following 4 sections for completion:

1. Header
2. Body
3. Option Boxes
4. 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 (SNF ABN)" 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 patient receiving the notice, and a middle initial should be entered if there is one on the patient's Medicare card. The SNF ABN will still be valid if there's a misspelling or missing initial, as long as the patient or their authorized representative recognizes the name 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 patient may be responsible for paying for care that Medicare isn't expected to cover.

B. "Care" Section

In this section, the SNF utilizes the appropriate check boxes to indicate the care that it believes may not or won't be covered by Medicare. These include Physical Therapy, Occupational Therapy, Daily Skilled Nursing Care and Other. If Other is checked, the SNF must enter the exact nature of the service that had previously been provided. The description must be written in plain language that the patient can understand.

C. "Reason Medicare May Not Pay" Section

The SNF must give the applicable Medicare coverage guideline(s) and a brief explanation of why the patient's medical needs or condition do not meet Medicare coverage guidelines. The reason must be sufficient and specific enough to enable the patient 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: Patient no longer requires daily skilled care but wants to continue residing in the SNF.

> **Care:** Inpatient Skilled Nursing Facility Stay requiring daily skilled care which includes custodial room and board charges.
> **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, including custodial care room and board charges, at this facility unless you require daily skilled care.

Example 2: Patient no longer requires daily skilled care (includes daily skilled nursing and/or therapy plus custodial care room and board) but wants to continue residing in the SNF.

> **Care:** Inpatient Skilled Nursing Facility Stay, includes daily skilled nursing and/or therapy plus custodial care room and board)
> **Reason Medicare May Not Pay:** You don't require skilled care on a daily basis. Medicare won't pay for your stay (custodial care room and board) at this facility unless you need daily skilled care for your medical condition.

Example 3: Patient no longer requires skilled therapy services (includes daily skilled nursing and/or therapy plus custodial care room and board) and wants to continue residing in the SNF.

> **Care:** Inpatient Skilled Nursing Facility Stay (includes daily skilled nursing and/or therapy plus custodial care room and board)
> **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 (custodial care room and board) 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 SNF ABN or an amount that is different than the final actual cost charged to the beneficiary does not invalidate the SNF ABN.

If for some reason the SNF is unable to provide a good faith estimate of projected costs of care at the time of SNF ABN 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 SNF ABN 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 SNF ABN, in general. SNFs should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated a SNF ABN.

2. Option Boxes

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

Option 1:

☐ **Option 1.** I want the daily skilled care, which includes custodial room and board charges.. 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 does not pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

When the patient selects Option 1, the care is provided, and the SNF must submit a claim to Medicare. The SNF must notify the patient 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: Patients 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(s) listed above, which includes custodial services and room and board charges, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care(s). **I cannot appeal because Medicare won't be billed.**

When the patient selects Option 2, the care is provided, and the patient pays for it out-of-pocket. The SNF does not submit a claim to Medicare. Since there is no Medicare claim, the patient 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 do not want the care(s) listed above. I understand that I am not responsible for paying, and **I cannot appeal to see if Medicare would pay**. Medicare Part B may cover some of my care, excluding Room and Board, for which I would be responsible for paying.

When the patient selects Option 3, the care, which includes custodial room and board charges is not provided, and there is no charge to the patient. The SNF may bill Medicare Part B for Part B therapies as appropriate.

4. Signature and Date

The patient 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 patient needs help. This date should reflect the date that the SNF gave the notice to the patient in-person, or when appropriate, the date contact was made with the patient's authorized representative by phone. If an authorized representative signs for the patient, 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 patient refuses to choose an option and/or refuses to sign the SNF ABN when required, the SNF should annotate the original copy of the SNF ABN indicating the refusal to sign and may list a witness to the refusal. The SNF should consider not furnishing the care.

Completing the SNF ABN as a voluntary notice

The SNF ABN 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 SNF ABN is issued voluntarily, and alternatively, SNFs may develop their own written notice for care that is never covered. When the SNF ABN is being issued as a voluntary notice, the patient does not 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 SNF ABN.

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.