CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4198	**Date: January 11, 2019**
	Change Request 10567

Transmittal 4011, dated March 30, 2018, is being rescinded and replaced by Transmittal 4198, dated January 11, 2019, to remove sections/subsections 70.1.1, 70.1.2, 70.1.3, 70.2.1, 70.2.2, 70.2.2.1, 70.2.2.2, 70.2.2.3, 70.2.2.4, 70.2.2.5, 70.2.3, 70.2.3.1, 70.2.3.2, 70.2.3.3, 70.2.4, 70.2.5, 70.3.1, 70.3.2, 70.3.3, 70.3.4, 70.3.5, 70.4.1, 70.4.1.1, 70.4.1.2, 70.4.1.3, 70.4.2, 70.4.2.1, 70.4.2.2, 70.4.3, 70.4.3.1, 70.4.3.2, 70.4.3.3, 70.4.3.4, 70.4.3.5, 70.4.3.6, 70.4.3.7, 70.4.3.8, 70.4.3.9, 70.4.3.10, 70.4.3.11, 70.4.4, 70.4.4.1, 70.4.4.2, 70.4.4.3, 70.4.5, 70.6.1.1, 70.6.1.2, 70.6.1.3, 70.6.1.4, 70.6.2, 70.6.3, 70.6.4, 70.6.5, 70.6.6, 70.6.7, 70.6.8, 70.6.9, 70.6.9.1, 70.6.9.2, 70.6.9.3, 70.6.9.4, 71, 72, 73, 74, 75, 75.1 and revise sections/subsections 70, 70.1, 70.2, 70.3, 70.4, 70.5, 70.6, 70.6.1 in chapter 30 of Pub. 100-04. These sections/subsections should have been removed or revised in the previous transmittal. All other information from the transmittal remains the same.

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

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to revise the SNF ABN, Form CMS-10055. With this revision, CMS is discontinuing the 5 SNF Denial Letters and the Notice of Exclusion from Medicare Benefits (NEMB-SNF), Form CMS-20014.

EFFECTIVE DATE: April 30, 2018 - Please note that SNFs may start to implement this new notice any time up to the effective date, which will then be mandatory for use.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 30, 2018 - Please note that SNFs may start to implement this new notice any time up to the implementation date, which will then be mandatory for use.

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

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

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D	30/70/70.1/70.1.3/Where to Obtain the SNFABN Form
R	30/70/70.2/Situations in Which a SNF ABN Should Be Given
D	30/70/70.2/70.2.1/When and to Whom a SNFABN Should Be Given
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D	30/70/70.2/70.2.3/Situations in Which SNFABN Should Be Given
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D	30/70/70.2/70.2.3/70.2.3.2/Dual-Eligibles
D	30/70/70.2/70.2.3/70.2.3.3/Medicare as Sole Payer
D	30/70/70.2/70.2.4/Routine SNFABN Prohibition
D	30/70/70.2/70.2.5/To Whom a SNFABN Should Be Given
R	30/70/70.3/Situations in Which a SNF ABN Is Not Needed to Transfer Financial Liability to the Beneficiary
D	30/70/70.3/70.3.1/Delivery Must Meet Advance Beneficiary Notice Standards
D	30/70/70.3/70.3.2/SNFABN Specific Delivery Issues
D	30/70/70.3/70.3.3/Timely Delivery
D	30/70/70.3/70.3.4/Actual Receipt of Notice Required
D	30/70/70.3/70.3.5/Understandability and Comprehensibility of Notice
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	30/70/70.4/70.4.1/70.4.1.2/Guidelines for Replicating the SNFABN Form
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D	30/70/70.4/70.4.2/Header of SNFABN
D	30/70/70.4/70.4.2/70.4.2.1/Customization of CMS-10055 SNFABN Header
D	30/70/70.4/70.4.2/70.4.2.2/Guidelines for Customizing the SNFABN Header
D	30/70/70.4/70.4.3/Body of SNFABN
D	30/70/70.4/70.4.3/70.4.3.1/Entering the Required Date(s) on the CMS-10055 SNFABN
D	30/70/70.4/70.4.3/70.4.3.2/Specifications Required for the “Items or Services” Section of the SNFABN
D	30/70/70.4/70.4.3/70.4.3.3/Specifications Required for the “Because” Section of the SNFABN
D	30/70/70.4/70.4.3/70.4.3.4/Answering Inquiries About the SNFABN Notification
D	30/70/70.4/70.4.3/70.4.3.5/Providing Cost Estimation(s) for Items or Services on the SNFABN
D	30/70/70.4/70.4.3/70.4.3.6/Providing Non-Medicare Insurance Information on the SNFABN
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D	30/70/70.4/70.4.3/70.4.3.10/Providing the Medicare Health Insurance Claim Number on the SNFABN
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D	30/70/70.6/70.6.1/70.6.1.1/Effective Notice

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	30/70/70.6/70.6.1/70.6.1.2/Defective Notice
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D	30/70/70.6/70.6.4/Effect of SNFABN on Beneficiary
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D	30/70/70.6/70.6.9/Standards
D	30/70/70.6/70.6.9/70.6.9.1/Establishing When Beneficiary is On Notice of Noncoverage
D	30/70/70.6/70.6.9/70.6.9.2/Source of Beneficiary Notification
D	30/70/70.6/70.6.9/70.6.9.3/Determining the Notification Date for the Denial Paragraph
D	30/70/70.6/70.6.9/70.6.9.4/Requesting a Medicare Decision
D	30/71/Situations in Which a SNF ABN Should Be Given
D	30/72/Situations in Which a SNF ABN Is Not Needed to Transfer Financial Liability to the Beneficiary
D	30/73/SNF ABN Specific Delivery Issues
D	30/74/Special Rules for SNF ABNs
D	30/75/Establishing When Beneficiary Is On Notice of Non-coverage
D	30/75/75.1/Source of Beneficiary Notification

III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4198	Date: January 11, 2019	Change Request: 10567

Transmittal 4011, dated March 30, 2018, is being rescinded and replaced by Transmittal 4198, dated January 11, 2019, to remove sections/subsections 70.1.1, 70.1.2, 70.1.3, 70.2.1, 70.2.2, 70.2.2.1, 70.2.2.2, 70.2.2.3, 70.2.2.4, 70.2.2.5, 70.2.3, 70.2.3.1, 70.2.3.2, 70.2.3.3, 70.2.4, 70.2.5, 70.3.1, 70.3.2, 70.3.3, 70.3.4, 70.3.5, 70.4.1, 70.4.1.1, 70.4.1.2, 70.4.1.3, 70.4.2, 70.4.2.1, 70.4.2.2, 70.4.3, 70.4.3.1, 70.4.3.2, 70.4.3.3, 70.4.3.4, 70.4.3.5, 70.4.3.6, 70.4.3.7, 70.4.3.8, 70.4.3.9, 70.4.3.10, 70.4.3.11, 70.4.4, 70.4.4.1, 70.4.4.2, 70.4.4.3, 70.4.5, 70.6.1.1, 70.6.1.2, 70.6.1.3, 70.6.1.4, 70.6.2, 70.6.3, 70.6.4, 70.6.5, 70.6.6, 70.6.7, 70.6.8, 70.6.9, 70.6.9.1, 70.6.9.2, 70.6.9.3, 70.6.9.4, 71, 72, 73, 74, 75, 75.1 and revise sections/subsections 70, 70.1, 70.2, 70.3, 70.4, 70.5, 70.6, 70.6.1 in chapter 30 of Pub. 100-04. These sections/subsections should have been removed or revised in the previous transmittal. All other information from the transmittal remains the same.

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

EFFECTIVE DATE: April 30, 2018 - Please note that SNFs may start to implement this new notice any time up to the effective date, which will then be mandatory for use.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 30, 2018 - Please note that SNFs may start to implement this new notice any time up to the implementation date, which will then be mandatory for use.

I. GENERAL INFORMATION

A. Background: Historically, SNF providers were instructed to issue the SNFABN, Form CMS-10055 or one of the 5 SNF Denial Letters for items and services paid under Medicare Part A and the ABN, Form CMS R-131 for items or services paid under Medicare Part B to inform Original Medicare beneficiaries of their potential laibility in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act (the Act). The NEMB-SNF was used as a voluntary notice to inform beneficiaries of potential liability for items and services that are either subject to statutory denials (i.e. never covered by Medicare) or do not meet technical eligibility requirements (i.e. no qualfying 3-day stay).

In order for SNFs to transfer financial liability to an Original Medicare beneficiary for items or services paid under Medicare Part A (SNF Prospective Payment System), the SNF must issue a SNF ABN for:

- an item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or
- custodial care.

SNFs will continue to use the ABN, Form CMS-R-131 for items or services that may be denied by Medicare paid under Medicare Part B to inform beneficiaries of their potential liability.

The revised SNF ABN replaces the formerly used SNF ABN, the 5 SNF Denial Letters, and the NEMB, Form CMS-20014.

The revised notice incorporates suggestions for changes made by users of the ABN and by beneficiary advocates based on experience with the current form, refinements made to similar liability notices through consumer testing and other means, as well as related Medicare policy changes and clarifications.

B. Policy: Section 1879 of the Act and 42 CFR 411.404(b) and (c)

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10567.1	Contractors shall accept a properly executed revised SNF ABN, Form CMS-10055, as valid notification beginning on the date of issuance of this change request. However, the mandatory date of use for SNFs to use this notice will be 30 days from issuance of this CR.	X	X							
10567.2	Contractors shall review the process associated with the revised SNF ABN as indicated in the Pub. 100-04, Chapter 30, Section 70.	X	X							
10567.3	Contractors shall perform additional individual provider education if alerted that a notifier is not complying with these instructions.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10567.4	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Jennifer McCormick, 410-786-2852 or Jennifer.McCormick1@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

Table of Contents
(Rev. 4198, Issued: 01-11-19)

Transmittals for Chapter 30

70 - *Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN)*
(Rev.: 4198; Issued: 01-11-19; Effective: 04-30-18; Implementation: 04-30-18)

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

SNF ABN - Quick Glance Guide[1]

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

Additional Information:

The ABN, Form CMS-R-131 should be used for Part B non-covered items or services. SNFs should no longer use the 5 SNF Notices of Non-coverage (Denial Letters) or the NEMB-SNF (CMS-20014) as these have been discontinued with the 2018 SNF ABN revision.

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

70.1 – *SNF ABN Standards*
(Rev.: 4198; Issued: 01-11-19; Effective: 04-30-18; Implementation: 04-30-18)

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

70.2 - *Situations in Which a SNF ABN Should Be Given*
(Rev.: 4198; Issued: 01-11-19; Effective: 04-30-18; Implementation: 04-30-18)

A. Triggering Events

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

A SNF ABN is evidence of beneficiary knowledge about the likelihood of a Medicare denial, for the purpose of determining financial liability for expenses incurred for extended care items or services furnished to a beneficiary and for which Medicare does not pay. If Medicare is expected to deny payment (entirely or in part) on the basis of one of the exclusions listed in §70 of this chapter for extended care items or services that the SNF furnishes to a beneficiary, a SNF ABN must be given to the beneficiary in order to transfer financial liability for the item or service to the beneficiary. The initiation, reduction and termination of such extended care items or services, that Medicare may not pay, are considered triggering events. The following describe the three triggering events for a SNF ABN:

EVENT	DESCRIPTION
Initiation	*In the situation in which a SNF believes Medicare will not pay for extended care items or services that a physician has ordered, the SNF must provide a SNF ABN to the beneficiary before it furnishes those non-covered extended care items or services to the beneficiary.*
Reduction	*In the situation in which a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide a SNF ABN to the beneficiary before it reduces items or services to the beneficiary.*
Termination	*In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF must provide a SNF ABN to the beneficiary before it terminates such extended care items or services.*

B. Effect of Other Insurers/Payers

Some States have specific rules established regarding completion of liability notices in situations where dual-eligibles need to accept liability for Medicare non-covered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort", meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. If the patient is a Medicare-Medicaid dual-eligible and a triggering event occurs, the SNF needs to give the beneficiary a SNF ABN.

On a practical basis, physician-prescribed items or services continue without interruption or reduction when a patient changes "payer eligibility" from Medicare to Medicaid. From the Medicare coverage vantage-point, however, there is a reduction or termination when Medicare, which has been paying, stops paying. In other words, there is a triggering event, which underlies the change in "payer eligibility." In these instances, a SNF ABN must be issued to transfer financial liability to the beneficiary.

70.3 - *Situations in Which a SNF ABN Is Not Needed to Transfer Financial Liability to the Beneficiary*

(Rev.: 4198; Issued: 01-11-19; Effective: 04-30-18; Implementation: 04-30-18)

SNFs need not issue a SNF ABN to transfer financial liability to the beneficiary:

- *If the extended care item or service is not a Medicare benefit (e.g., personal comfort items excluded under §1862(a)(6)).*

- *If a beneficiary is being furnished post-hospital extended care services while a resident in a SNF and payment is expected to be denied for an otherwise Medicare covered benefit because it does not meet a technical benefit requirement (e.g., SNF stay not preceded by the required prior three-day hospital stay or the beneficiary is exhausting his/her 100 benefit days).*

- *If Medicare is expected to deny payment for Part B covered medical and other health services which the SNF furnishes, either directly or under arrangements with others, to an inpatient of the SNF, where payment for these services cannot be made under Part A (e.g., the beneficiary has exhausted his/her allowed days of inpatient SNF coverage under Part A in his/her current spell of illness or was determined to be receiving a non-covered level of care).*

- *If the SNF will not furnish the extended care items or services. A SNF must not give a beneficiary a SNF ABN and then refuse to furnish extended care items or services even though the beneficiary elects to receive these items or services by selecting Option 1, as this is equivalent to the prohibited practice of the SNF pre-selecting Option 2 (not to receive items or services) on a SNF ABN. This rule also applies when the beneficiary agrees with the triggering event (i.e., terminating therapy) and the beneficiary will not be receiving the extended care items or services.*

  NOTE: *This rule is not applicable in the situation where the beneficiary elects to receive extended care items or services but refuses to sign the SNF ABN attesting to being personally and fully responsible for payment, in which case, the SNF may then consider not furnishing the specified items or services.*
- *For Medicare Advantage (Part C) enrollees nor for non-Medicare patients because it is to be used solely for individuals enrolled in the Medicare FFS program (Parts A and B).*

- *When extended care items or services are reduced or terminated in accordance with a physician's order, where a physician does not order the items or services at issue, or where the physician agrees in writing with the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that the extended care items or services are not necessary.*

- *For swing-bed determinations. The Preadmission/Admission HINN (HINN 1) should be given.*

NOTE: *An ABN, Form CMS-R-131 may be required if a SNF has been acting as a supplier of Part B services or supplies outside a physician's plan of care. See Section 50 of this manual, as applicable.*

70.4 – *SNF ABN Specific Delivery Issues*

(Rev.: 4198; Issued: 01-11-19; Effective: 04-30-18; Implementation: 04-30-18)

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

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

70.5 - *Special Rules for SNF ABNs*

(Rev.: 4198; Issued: 01-11-19; Effective: 04-30-18; Implementation: 04-30-18)

A. Collection from Beneficiary

When a SNF ABN is properly executed and given timely to a beneficiary and Medicare denies payment on the related claim, the SNF must wait for the beneficiary to receive a Medicare Summary Notice (MSN) before it can collect payment on the related claim. Medicare does not limit the amount that the SNF may collect from the beneficiary in such a situation. A beneficiary's agreement to "be personally and fully responsible for payment" means that the beneficiary agrees to pay out of pocket or through any other insurance that the beneficiary may have, e.g., through employer group health plan coverage, through Medicaid, or through some other Federal or non-Federal payment source.

NOTE: *The beneficiary may request a demand bill at any point in her or his care.*

B. Unbundling Prohibition

The SNF ABNs may not be used to shift financial liability to a beneficiary in the case of services for which full payment is bundled into other payments; that is, where the beneficiary would otherwise not be financially liable for payment for an extended care item or service because Medicare made a bundled payment. Using a SNF ABN to collect from a beneficiary where full payment is made on a bundled basis would constitute double billing. A SNF ABN may be used to shift financial liability to a beneficiary in the case of extended care items or services for which partial payment is bundled into other payments; that is, where part of the cost is not included in the bundled payment made by Medicare.

C. Acceptance or Rejection of SNF ABN

These instructions are to assist the Medicare contractor in advising SNFs with respect to their responsibilities in advising beneficiaries with respect to their rights and protections and in dealing with complaints from beneficiaries, or authorized representatives, about the lack of notice or defective notice. The SNF should:

- *Answer inquiries from a beneficiary regarding the basis for the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that extended care items or services may not be covered and, if requested by the beneficiary, the SNF must give the beneficiary access to medical record information or other documents upon which these entities based their assessment, to the extent permissible or required under applicable state law.*

  NOTE: *Where state law prohibits such direct disclosure, the SNF should advise a beneficiary who has requested access to such information how to obtain that information from the SNF once a demand bill has been submitted.*

- *Respond timely, accurately, and completely to a beneficiary who requests information about the extent of the beneficiary's personal financial liability.*

- *Timely submit additional information to the Medicare contractor, if a beneficiary or a physician provides that additional information with respect to Medicare coverage of the subject extended care items or services.*

70.6 – *Establishing When Beneficiary Is On Notice of Non-coverage*
(Rev.: 4198; Issued: 01-11-19; Effective: 04-30-18; Implementation: 04-30-18)

If the beneficiary has previously been informed in writing that similar or reasonably comparable extended care items or services were non-covered and it was clear that the beneficiary knew that the circumstances were the same, the beneficiary is liable. With this exception, the beneficiary is presumed not to have known, nor to have been expected to know, that the extended care items or services are not covered unless, or until, s/he receives notification from an appropriate source.

70.6.1 - *Source of Beneficiary Notification*
(Rev.: 4198; Issued: 01-11-19; Effective: 04-30-18; Implementation: 04-30-18)

Written Notification must be given by one of the following sources:

A. The SNF that is furnishing non-covered extended care items or services.

Examples:

- *On or before the day of admission, the SNF furnishes to the beneficiary a SNF ABN notifying the beneficiary that the extended care item(s) or service(s) is non-covered; or*

- *During the inpatient stay, the SNF timely furnishes to the beneficiary a SNF ABN notifying the beneficiary that the covered extended care item(s) or service(s) will no longer be covered.*

B. The UR entity of the SNF that is furnishing non-covered extended care items or services.

Example:

- *The UR entity timely furnishes to the beneficiary a SNF ABN notifying the beneficiary that the extended care item(s) or service(s) is no longer covered.*

C. The QIO or Medicare contractor.

Example:

- *The QIO, where a beneficiary is in a swing bed, timely furnishes to the beneficiary, a SNF ABN notifying the beneficiary that the extended care item(s) or service(s) is not covered or the item(s) or service(s) is no longer covered.*

  NOTE: *This occurs after the beneficiary receives a HINN 1 (Preadmission/Admission HINN) and after the QIO's decision of the non-coverage.*

- *The Medicare contractor sends the beneficiary her or his first notification of non-coverage (e.g., the MSN).*