

Liability Notices & Beneficiary Appeal Rights Review

Facility Name: _____ Facility ID: _____ Date: _____

Surveyor Name: _____

This task is only completed at Medicare-participating facilities.

During the entrance conference, obtain a list of Medicare beneficiaries who requested demand bills in the past six months. The QIS DCT will randomly select three Medicare beneficiaries discharged from the SNF in the past six months for inclusion in the closed record review section of this task.

If an SNF provider believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and that an otherwise covered item or service may be denied as not reasonable and necessary, the facility must notify the resident or his/her legal representative in writing.

This notice requirement may be fulfilled by use of either the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) (CMS form 10055) or one of the five uniform Denial Letters found in §358 of the Skilled Nursing Facility Manual. The SNFABN and the Denial Letters inform the beneficiary of his/her right to have a claim submitted to Medicare and advises them of the standard claim appeal rights that apply if the claim is denied by Medicare. These claims are often referred to as "demand bills"¹ and are reviewed by the Fiscal Intermediary (FI) or Medicare Administrative Contact (MAC).

The SNF must issue the Notice of Medicare Provider Non-coverage (CMS form 10123) when there is a termination of all Medicare Part A services for coverage reasons. The Notice of Medicare Provider Non-coverage informs the beneficiary of his/her right to an expedited review of a service termination by the Quality Improvement Organization (QIO). The Notice to Medicare Provider Non-coverage is sometimes referred to as an "Expedited Appeal Notice" or a "Generic Notice." The SNF should not issue this notice if the beneficiary exhausts the Medicare covered days as the number of SNF benefit days is set in law and the QIO cannot extend the benefit period. Thus, a service termination due to the exhaustion of benefits is not considered a termination for "coverage" reasons.

The SNF:

- Must keep a copy of the appropriate liability and beneficiary appeal rights notices, such as the SNFABN, Denial Notice, and/or the Notice of Medicare Provider Non-coverage on file;
- Must file a claim when requested by the beneficiary; and
- May not charge the resident for Medicare covered Part A services while a decision is pending.

Failure to provide written liability of payment and/or appeal notice(s), to submit the bill (if requested by a resident), or to charge the resident for Medicare covered Part A services while a decision is pending may constitute a violation of the facility's provider agreement. Refer to S&C 09-20 or go to <http://www.cms.hhs.gov/bni/> for more details about liability notices and resident appeal rights.

¹ See Ch. 1, §60.3 of the Medicare Claims Processing Manual for detailed instructions on submitting institutional demand bills.

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Review	Notes
<p>1. Did any Medicare beneficiaries request a demand bill in the past six months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>IF NO, Mark questions 2 and 3 “NA, no Medicare beneficiaries requested a demand bill in the past six months” and complete the section “Closed record review for three Medicare beneficiaries who were discharged from the SNF in the past six months”.</i></p> <p><i>IF YES, Complete questions 2 through 6.</i></p> <p>From the list of Medicare beneficiaries who requested demand bills in the past six months, randomly select one resident’s file to determine whether the facility submitted the bill to the FI or MAC within the required timeframe.</p> <p>Name and Resident Identifier of Medicare beneficiary who requested a demand bill in the past six months:</p> <p>_____</p> <p>Note: Medicare claims must be filed within one full calendar year following the year in which the services were provided (e.g., October 1, 2007 – September 30, 2008 submitted by December 31, 2009).</p>	

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Review	Notes
Record review for the Medicare beneficiary(ies) who requested a demand bill in the past six months:	
<div style="margin-bottom: 10px;"> <input type="checkbox"/> Review the resident's file to determine whether the facility submitted the bill to the FI or MAC within the required timeframe. </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> Determine whether the facility charged the resident for Medicare covered Part A services while a decision is pending. </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> If the facility failed to submit the bill to the FI or MAC within the required timeframe or charged the resident while the decision was pending, the facility is in violation of the provider agreement with respect to resident billing requirements. Cite tag F492, 42 C.F.R. § 483.75(b), Compliance with Federal, State and local laws and professional standards and refer to 42 C.F.R. § 489.21, Specific limitations on charges. </div> <div style="background-color: #d3d3d3; padding: 5px; margin-bottom: 10px;"> 2. Did the facility submit the bill to the FI or MAC within the required timeframe? (If the bill has not been submitted but the required timeframe has not expired, mark NA.) <div style="text-align: right; margin-right: 50px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No F492 </div> <input type="checkbox"/> NA, no Medicare beneficiaries requested a demand bill in the past six months OR a bill was not submitted but the required timeframe has not expired </div> <div style="background-color: #d3d3d3; height: 40px; margin-bottom: 10px;"></div> <div style="background-color: #d3d3d3; padding: 5px;"> 3. Did the facility stop charging the resident while the decision was pending? <div style="text-align: right; margin-right: 50px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No F492 </div> <input type="checkbox"/> NA, no Medicare beneficiaries requested a demand bill in the past six months </div>	

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Review	Notes

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Review	Notes
Closed record review for three Medicare beneficiaries who were discharged from the SNF in the past six months:	
<p>Medicare beneficiaries randomly selected for this review from the facility's SNF-discharged residents.</p> <p>1) Name and Resident Identifier of Medicare beneficiary who was discharged from the SNF: _____</p> <p>2) Name and Resident Identifier of Medicare beneficiary who was discharged from the SNF: _____</p> <p>3) Name and Resident Identifier of Medicare beneficiary who was discharged from the SNF: _____</p> <p><input type="checkbox"/> Look for a copy of appropriate liability and appeal notice(s). If the facility failed to provide the resident the appropriate liability and/or appeal notice(s), the facility is in violation of the notice requirements. Cite tag F156, 42 C.F.R. 483.10, Resident rights.</p> <p><input type="checkbox"/> If the record indicates the resident requested the facility submit the bill for appeal, determine whether the facility submitted the bill to the FI or MAC within the required timeframe. Medicare claims must be filed within one full calendar year following the year in which the services were provided (e.g., October 1, 2007 – September 30, 2008 submitted by December 31, 2009). If the facility failed to submit the bill to the FI or MAC within the required timeframe or charged the resident while the decision was pending, the facility is in violation of the provider agreement with respect to resident billing requirements. Cite tag F492, 42 C.F.R. § 483.75(b), Compliance with Federal, State and local laws and professional standards and refer to 42 C.F.R. § 489.21, Specific limitations on charges.</p> <p style="background-color: #d3d3d3;">4. Did the facility provide the appropriate liability and appeal notice(s)?</p> <div style="text-align: right; padding-right: 50px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No F156 </div>	

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Closed record review for three Medicare beneficiaries who were discharged from the SNF in the past six months:	
<p>5. Did the facility submit the bill(s) to the FI or MAC within the required timeframe? <input type="checkbox"/> Yes <input type="checkbox"/> No F492</p> <p><input type="checkbox"/> NA, none of the three residents from the closed record review requested a demand bill OR a bill was not submitted but the required timeframe has not expired</p> <p>6. Did the facility stop charging the resident(s) while the decision was pending? <input type="checkbox"/> Yes <input type="checkbox"/> No F492</p> <p><input type="checkbox"/> NA, none of the three residents from the closed record review requested a demand bill</p>	