SNF Notice of Non-Coverage Guidelines

As of 2014

Form Name	Form #	Situation Form Is Used For	Timing
NOMNC (Notice of Medicare Non-Coverage)	**CMS-1023 (Updated 12/31/11)**	Medicare Part A coverage ending (drop to non-skilled level) and has Part A days left- either staying or leaving certified bed	Need to issue form at least 2 calendar days before Medicare covered services end. If resident is leaving certified bed or being discharged from the facility, the NOMNC is the only form needed. If staying in a certified bed, need to give the NOMNC and the SNF ABN/Denial Letter. ***(ISSUE IF CUT OR DC FROM FACILITY)***
		Medicare Part A resident is being discharged from facility	
		Purpose is to inform resident of right to expedited appeal of termination of services/discharge	
		For residents admitted that did not qualify for Part A and received skilled therapy services under Part B OR for those that exhausted A and continued skilled therapy under B, issue form CMS-R-131 upon completion of Med B services (see below)	
SNF ABN OR Denial Letter (SNF Advanced Beneficiary Notice / Letters of Non-Coverage)	**CMS-10055**	Medicare Part A coverage ending (drop to non-skilled level) and has Part A days left and will remain in certified bed after last covered day	On the last day of coverage when resident requests expedited review from QIO. Can issue SNF ABN or 1 of 5 SNF Denial Letters
		Medicare Part A coverage ending and custopdia care will be provided	If staying, issue on last covered day. Issue prior to providing custodial care. ***(ISSUE IF CUT AND STAYING IN FACILITY OR IF QIO REVIEW REQUESTED)***
DENC (Detailed Explanation of SNF Non-Coverage)	**CMS-10124 (Updated 12/31/11)**	Purpose is to provide resident with info after they request appeal from QIO when the NOMNC was given	Provide to resident by close of business on the day QIO tells facility that the resident appealed the termination of services ***(ISSUE IF QIO REVIEW REQUESTED)***
ABN (Part B Advanced Beneficiary Notice)	**CMS-R-131 (Updated 3/2011)**	Medicare Part B resident wants to continue therapy after services are no longer medically necessary and the facility plans to provide the services. This includes if resident has or has not reached the therapy cap.	Required if SNF feels services are not reasonable and necessary. Form needs to be provided prior to providing services. Optional if services are excluded by statue. Do not need to give form if services aren't going to be provided after discontinuation of medically necessary therapy.
		*This form does not cover therapy provided beyond the cap that is denied by Medicare or any therapy service denied by Medicare that was thought to be necessary/skilled	
		For residents admitted that did not qualify for Part A and received skilled therapy services under Part B OR for those that exhausted A and continued skilled therapy under B, issue form CMS-R-131 upon completion of Med B services (see below)	
NEMB-SNF (Notice of Exclusion from Medicare Benefits)	**CMS-20014 (Optional)**	New admission not eligible for Part A (i.e.: No qualifying stay)	If for a resident that is not eligible for Part A on admission or readmission, the form needs to be given that day. Nothing is required when benefits exhaust but can give form on last day.
		Readmission not eligible for Part A	
		Medicare does not cover services/procedure (It is excluded by statue)	
		Resident exhausts 100 day benefit period	
		Purpose is to inform resident of ineligibility for Part A or that services are excluded by statute	

*If Medicare Part coverage ends by resident choice (service not wanted) no forms are required

**If resident is on a Part B program that is less than 5x/wk (i.e.: Does not meet Skilled requirements of 5x/wk for Part A), or if the resident is on a Part B program that is not an extension from a Med A covered stay, no forms are needed (i.e.: Resident is long-term care, is placed on PT 3x/wk for 4 wks for decline. No forms necessary when therapy program is discharged by PT and physician.)

Regulations based on CFR (42 CFR CH. IV (10-1-05 Edition) Section 405.1200 and Medicare Claims Processing Manual, Chapter 30, Section 50