

Liability Notices & Beneficiary Appeal Rights Review (formerly Demand Billing Review)

Facility Name: _____ Facility ID: _____ Date: _____

Surveyor Name: _____

This task is only completed at Medicare-participating facilities. (See Step 49 of the QIS Checklist for instructions on removing the Demand Billing task for a Medicaid-only facility).

NEW INSTRUCTIONS FOR COMPLETION: The F tag selection, guidance, and language provided in this document are not consistent with the Demand Billing task in the QIS DCT. Pending a revision to the QIS DCT and as an interim procedure:

- 1) The team coordinator assigns the Demand Billing task in the QIS DCT during Stage II sample assignment.
- 2) The assigned surveyor removes the Demand Billing task in the QIS DCT from the **Stage II Critical Elements** screen, by selecting the **Remove Care Area** button. On the **Reason for Care Area Removal** window, select **Other** and specify “S&C0920”.
- 3) The assigned surveyor completes the **Liability Notices & Beneficiary Appeal Rights Review** worksheet according to the instructions in this document, using S&C letter 09-20.
 - a. If the surveyor determines compliance, initiate the applicable F tag for the facility and mark the compliance question **Yes** (if the response to questions 2 and 6 is NA, mark the compliance decision in the QIS DCT **Yes**). (See Step 42 of the QIS Checklist for instructions on initiating an F tag for a resident. For the instructions to “Select the Care Area in the **Available Care Areas** pane...” select the **F Tag Direct Cite** option to display and select from the list of available F tags.
 - b. If the surveyor determines noncompliance, initiate the applicable F tag for the resident(s), mark the compliance question **No**, and document the findings. (Follow QIS Checklist Step 42 instructions as referenced in Step 3a above.)

During the entrance conference, obtain a list of Medicare beneficiaries who requested demand bills in the past six months. In addition, request that the facility provide a list of Medicare beneficiaries discharged from the SNF in the past six months.

If a 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

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

Liability Notices & Beneficiary Appeal Rights Review (formerly Demand Billing Review)

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

Review	Notes
<p>1. Did any Medicare beneficiaries request a demand bill in the past six months?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF NO, Skip to the section “Closed record review for three Medicare beneficiaries who were discharged from the SNF in the past six months” and answer questions 4 through 6.</p> <p>IF YES, Complete questions 2 and 3 and Closed record review.</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 if 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>	

Liability Notices & Beneficiary Appeal Rights Review (formerly Demand Billing Review)

Review	Notes
Record review for the Medicare beneficiary who requested a demand bill in the past six months	
<p><input type="checkbox"/> Review the resident's file to determine if the facility submitted the bill to the FI or MAC within the required timeframe.</p> <p><input type="checkbox"/> Determine if the facility charged the resident for Medicare covered Part A services while a decision is pending.</p> <p><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.</p> <p>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.) <input type="checkbox"/> Yes <input type="checkbox"/> No F492 <input type="checkbox"/> NA</p> <p>3. Did the facility stop charging the resident while the decision was pending? <input type="checkbox"/> Yes <input type="checkbox"/> No F492</p>	

Liability Notices & Beneficiary Appeal Rights Review (formerly Demand Billing Review)

Review	Notes
<p>Closed record review for three Medicare beneficiaries who were discharged from the SNF in the past six months</p>	
<p>Select three Medicare beneficiaries for this review from the facility list of discharged residents from the SNF.</p> <p>Name and Resident Identifier of Medicare beneficiary who was discharged from the SNF: _____</p> <p>Name and Resident Identifier of Medicare beneficiary who was discharged from the SNF: _____</p> <p>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 if 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>4. Did the facility provide the appropriate liability and appeal notice(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No F156</p>	

Liability Notices & Beneficiary Appeal Rights Review (formerly Demand Billing Review)

Review	Notes
<p>5. Did any of the three residents request a demand bill? <input type="checkbox"/> Yes <input type="checkbox"/> No (this form is complete)</p> <p>6. Did the facility submit the bill(s) 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.) <input type="checkbox"/> Yes <input type="checkbox"/> No F492 <input type="checkbox"/> NA</p> <p>7. Did the facility stop charging the resident(s) while the decision was pending? <input type="checkbox"/> Yes <input type="checkbox"/> No F492</p>	