CMS-20014 Form Instructions

For SNFs' Completion of the Notice of Exclusions from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF, form CMS-20014)

Upon final CMS approval of the Notice of Exclusions from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF), these instructions will be formally published in the Internet Only Manual, Pub.100-4 Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections.

70.8 – Notice of Exclusions from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF, form CMS-20014)
(Rev. x, xx-xx-04)

The NEMB-SNF, Form CMS-20014, is available online in English at the CMS Beneficiary Notices Initiative (BNI) Web page at http://www.cms.hhs.gov/medicare/bni/, under "Notice of Exclusions from Medicare Benefits – Skilled Nursing Facility [NEMB-SNF], Form CMS-20014. For online replicable copies of the Form CMS-20014 in Adobe Acrobat (PDF) format, go directly to:

CMS-20014 http://cms.hhs.gov/medicare/bni/CMS.20014_6.24.04..pdf

70.8.1 – Using the NEMB-SNF (CMS-20014)
(Rev. x, xx-xx-04)

Skilled nursing facilities must prepare and deliver to the patient, or to her or his authorized representative, an NEMB-SNF whenever they reduce or terminate extended care services, regardless of whether the reason for that change is a Medicare coverage determination, lack of physician certification, or the SNF's unwillingness to provide services for business reasons unrelated to coverage. For all expected denials of Medicare payments for skilled nursing care items and services for which a SNFABN (CMS-10055) or an ABN (CMS-R-131) is not used because neither LOL nor RR applies, SNFs must use the NEMB-SNF, Form CMS-20014, to advise patients, before items or services that are not Medicare benefits are furnished, that Medicare will not pay for them. NEMB-SNFs allow patients to make informed consumer decisions about receiving extended care items or services for which they must pay out-of-pocket and to be more active participants in their own health care treatment decisions. The NEMB-SNF is used, on a mandatory basis, by SNFs to advise their Medicare patients of the services that Medicare never covers, for which it is not appropriate to use ABNs.

70.8.2 - Using NEMB-SNFs With Categorical Denials
(Rev. x, xx-xx-04)

Skilled nursing facilities must prepare and deliver to the patient, or to her or his authorized representative, an NEMB-SNF when it is known that Medicare will not pay for, or will not continue to pay for, items or services on the basis of any categorical exclusion listed on the form in the Reason box. In this case, insert a mark in the pertinent check-off box or boxes. An NEMB-SNF **IS NOT** used for either of the following two categorical exclusions that trigger statutory protections:

- The service may be denied as "not reasonable and necessary" ("medical necessity") - §1862(a)(1) of the Act; or
- The service may be denied as "custodial care" - §1862(a)(9) of the Act.

70.8.3 - Using NEMB-SNFs With Technical Denials
(Rev. x, xx-xx-04)

Skilled nursing facilities must prepare and deliver to the patient, or to her or his authorized representative, an NEMB-SNF when it is known that Medicare will not pay for, or will not continue to pay for, items or services on the basis of any technical statutory exclusion, that is, for any failure to meet completely the statutory definition of a Medicare benefit. In this case, insert in the Reason box a mark in the pertinent check-off box or boxes, or if the exclusion is

not pre-printed, insert a mark in the check-off box for "Other:" and write the exclusion in the space provided after "Other:" An NEMB-SNF **IS NOT** used for any of the following six technical exclusions that trigger statutory protections:

- The home health care patient does not need intermittent skilled nursing care - §1814(a)(2)(C) [Part A] or §1835(a)(2)(A) [Part B] of the Act;
- The home health care patient is not confined to the home - §1814(a)(2)(C) [Part A] or §1835(a)(2)(A) [Part B] of the Act;
- The patient in hospice is found not to be terminally ill - §1861(dd)(3)(A) of the Act;
- The patient received a prohibited telephone solicitation ("cold call") in the case of medical equipment & supplies - §1834(a)(17)FIRST(B) of the Act;
- The supplier does not have a supplier number, in the case of medical equipment & supplies denials - §1834(j)(1) of the Act; or
- The supplier has not obtained a required advance coverage determination in the case of medical equipment & supplies denials - §1834(a)(15) of the Act.

70.9 – Form Instructions for the NEMB-SNF (CMS-20014)
(Rev. x, xx-xx-04)

70.9.1 – General Rules for NEMB-SNF
(Rev. x, xx-xx-04)

70.9.1.1 – When appropriate for use, the use of the Notice of Exclusions from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF) is mandatory.

70.9.1.2 –You (the skilled nursing facility) must ensure that the readability of the NEMB-SNF facilitates patient understanding. The standard form text must be in at least 12-point font. No insertions into the blanks, the "Items or Services" and Reason boxes, or customizable area (the header) of the NEMB-SNF, if typed or printed, should use italics or any font that is difficult to read; an Arial or Arial Narrow font, or a similarly readable font, in the font size range of 10 point to 12 point, is recommended for insertions. Black or dark blue ink on a white background is strongly recommended. A visually high-contrast combination of dark ink on a pale background is required. Low-contrast combinations and block shading are prohibited. If insertions are handwritten, they must be legible. In all cases, both the original and copies of the NEMB-SNF must be legible and of high-contrast.

70.9.2 – Header of NEMB-SNF
(Rev. x, xx-xx-04)

70.9.2.1 – The header, located above the form title, "Notice of Exclusions from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF)", is a customizable area of the CMS-20014, which you may customize for your use, consistent with the requirements of §70.9.2.2.

70.9.2.2 – The following elements must be included in the header. Within these general rules, you may customize the header. The NEMB-SNF header must include your identifying information, including your name, address and telephone number, and your TTY/TDD number or directions for using your other telecommunication system for individuals with impaired speech or hearing. You may elect to include your logo (if any).

70.9.3 – Body of NEMB-SNF
(Rev. x, xx-xx-04)

70.9.3.1 – On the line, "Date of Notice:_____", enter the date on which you gave the NEMB-SNF personally to the patient or to her or his authorized representative. Where personal delivery is not possible, include both the date you notified the patient by telephone and the date you mailed the notice.

70.9.3.2 – In the first box of the NEMB-SNF prefaced by the phrase, “Items or Services”, insert in the space provided the description of the items or services about which notice is being given. Avoid using abbreviations in this customizable box.

70.9.3.3 – Reason Box -- When you give an NEMB-SNF because you know Medicare will not pay for, or will not continue to pay for, items or services on the basis of any categorical statutory exclusion listed in the Reason box, insert a mark in the pertinent check-off box or boxes to the left of the specific exclusion. When you expect that Medicare will not pay for, or will not continue to pay for, items or services on the basis of any technical statutory exclusion, that is, for any failure to meet completely the statutory definition of a Medicare benefit, insert a mark in the pertinent check-off box or boxes to the left of the specific exclusion in the Reason box, or if the exclusion is not pre-printed, insert a mark in the check-off box for “Other:” and write the exclusion in the space provided after “Other:”. If you wish to also circle a pre-printed exclusion, or otherwise highlight it, that is permissible. The pre-printed exclusions in the Reason Box are furnished for the convenience of users; the Reason Box is a customizable section of the form. If a user wishes to leave the Reason Box open for its own entry/entries, it can eliminate the pre-printed exclusions and remove the part of the heading line therein that reads: "(See the reason checked off below.)"; but the rest of that line must remain as the heading for the Reason Box.

70.9.3.4 – On the line, “Ask us … will cost you (Estimated Cost: $_____)”, enter the estimated cost of the services. You are not required to express the cost estimate in any specific format. You must respond timely, accurately, and completely to a patient, or to her or his authorized representative, who requests information about the extent of the patient’s personal financial liability for skilled nursing care for which you expect that Medicare may not, or may no longer, pay. You must respond to the patient’s request for a cost estimate in terms that the patient can understand.

70.9.3.5 – The line, “Your other insurance is:”, is provided for a user, that is required by other instructions, to enter the name of the patient’s other insurance (e.g., Medicaid, Medigap, employee plan, etc.). If not otherwise required to do so, you may enter this information at your own discretion.

70.9.4 – Option Boxes for NEMB-SNF
(Rev. x, xx-xx-04)

70.9.4.1 – Do NOT pre-select any option.

70.9.4.2 – The patient must select one option.

A. If the patient, or her or his authorized representative, selects Option 1., the patient wants to receive the items or services. The patient agrees to be “personally and fully responsible for payment”, “either out of pocket or through any other insurance”. You must enter on the lines so designated the Medicare contractor’s telephone and TTY/TDD numbers.

B. If the patient, or her or his authorized representative, selects Option 2., the patient has elected to receive the subject items or services and to be “personally and fully responsible for payment of any amount for which my other insurance will not pay.” The patient, however, has elected NOT to exercise her or his right to have a claim for the subject items or services submitted to Medicare.

C. If the patient, or her or his authorized representative, selects Option 3., the patient has elected NOT to receive the subject items or services.

70.9.5 – Signature Requirements for NEMB-SNF
(Rev. x, xx-xx-04)

70.9.5.1 – On the line, "Patient's Name", enter the name of the patient (do not substitute the name of an authorized representative).

70.9.5.2 – On the line, **"**Medicare # (HICN)", enter the patient's health insurance claim number. An NEMB-SNF could be invalidated for the lack of a Medicare HICN if the patient-recipient of the NEMB-SNF alleges that someone else of the same name signed the form and the Medicare contractor cannot resolve the matter with certainty.

70.9.5.3 – On the line, "Signature of the patient or of the authorized representative", the patient, or her or his authorized representative, must sign his or her name. (See §40.3.5 for definition of "Authorized Representative.")

70.9.5.4 – On the line, "Date", the patient, or her or his authorized representative, enters the date on which she or he signed the NEMB-SNF.

70.9.6 – Dealing with Beneficiary's Refusal to Sign an NEMB-SNF

(Rev. x, xx-xx-04)

A patient (or her or his authorized representative) who has been given an NEMB-SNF may decide to receive the item or service. In this case, the patient should indicate by selecting Option 1. "YES" (demand bill) or Option 2. "YES" (no demand bill), that he or she is willing to be personally and fully responsible for payment. When a patient decides to decline an item or service, he or she should so indicate by selecting Option 3. "NO." The patient cannot properly refuse to sign the NEMB-SNF at all and still demand the item or service. Since neither LOL nor RR financial liability protections apply in the situations for which NEMB-SNFs are given, the NEMB-SNF is not determinative of financial liability. If a patient refuses to sign a properly executed NEMB-SNF, the SNF may consider not furnishing the item or service unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option. Additionally, the SNF may elect to annotate the NEMB-SNF, and have the annotation witnessed, indicating the circumstances and persons involved. If the patient demands the service and refuses to sign, the SNF may have a second person witness the provision of the NEMB-SNF and the patient's refusal to sign. They may both sign an annotation on the NEMB-SNF attesting to having witnessed said provision and refusal. An unused patient signature line on the NEMB-SNF form may be used for such an annotation; writing in the margins of the form is also permissible. Because neither LOL nor RR financial liability protections apply in the situations for which NEMB-SNFs are given, the patient will be held liable and the SNF will be able to collect from the patient, in case of a denial.

70.10 – Submitting a "Demand Bill" Claim to Medicare for Decision to Effectuate a Beneficiary's Selection on an NEMB-SNF

(Rev. x, xx-xx-04)

Whenever a beneficiary (or authorized representative) selects Option 1. "YES" on an NEMB-SNF and that beneficiary receives the services specified on the NEMB-SNF, the SNF shall submit the claim for those services to Medicare (i.e., submit a "demand bill"). The SNF is required to notify the patient or authorized representative when that claim has been submitted to the Medicare contractor. The SNF is prohibited from billing the patient or authorized representative for any items or services at issue until the contractor has determined coverage on the associated Medicare claim. (See Chapter 6, §40.7 of the Medicare Claims Processing Manual, "Other Billing Situations.") Any further "demand" beyond selection of Option 1. shall not be required of the beneficiary or authorized representative. The SNF's commitment to submit a claim when services are furnished and all the other notice process requirements under the May 1989 Sarrassat v. Sullivan settlement agreement are built into the NEMB-SNF form. Submission of such a claim results in an initial determination on the claim, which, in turn, allows the beneficiary (or authorized representative) to appeal the contractor's decision on the claim. (See Chapter 29 of the Medicare Claims Processing Manual, "Appeals of Claims Decisions.")