Notice	Purpose of Notice & Details	Triggering Events
PART B notices (available for download at: http://www.cms.hhs.gov/bni/		
Expedited Determination Notice Notice of Medicare Non-Coverage (NOMNC): CMS-10123 Detailed Explanation of Non-Coverage (DENC): CMS-10124	Providers are required to notify beneficiaries of their right to an expedited review of discharge of Medicare services. The NOMNC informs beneficiaries on how to request an expedited determination from their Quality Improvement Organization (QIO) and gives beneficiaries the opportunity to request an expedited determination from a QIO. The DENC is required when the beneficiary requests an expedited determination by the QIO (by noon of the day prior to LCD). DENC must be issued by the close of business of the day of the QIO notification. The QIO will review within 72 hours.	**Form CMS-10123** • All Part B services on a plan of care are ending • (i.e. last therapy discipline discharge) • NOT required when a reduction or termination of service does not end skilled Medicare • Issued no later than 2 days before covered services end **Form CMS-10124** • Beneficiary appeals the decision for discharge • Must be issued by close of business on date of QIO notification. QIO will review in 72 hrs.

Advanced Beneficiary Notice (ABN)
 	
Form: CMS R-131
	Issued by providers to Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied. Guidelines for mandatory and voluntary use of the ABN are published in the Medicare Claims Processing Manual, Chapter 30, Section 50.
	
	Note: Skilled nursing facilities (SNFs) must use the ABN for items/services expected to be denied under Medicare Part B only. Properly issued ABNs protect providers from financial liability for claims that Medicare does not pay for.
	
	Providers should take note of the newly incorporated expiration date on form CMS R-131. The form has been revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed. The effective date for use of this ABN form is 6/21/2017. There is now an expiration date attached to the form - March 2020
		Form CMS R-131
		• Issued before providing Part B services that are physician ordered and are any of the following:
		  ○ Not reasonable and necessary
		  ○ Custodial care
		  ○ Preventive services that have exceeded frequency limitations
		• You are NOT required to notify the beneficiary before you provide services that are never covered (statutorily excluded) by Medicare
		• An ABN should NOT be issued for medically necessary therapy over the cap, and should NOT be issued for medically necessary therapy over the $3700 threshold.

Notice	Purpose of Notice & Details	Triggering Events
PART A notices (available for download at: http://www.cms.hhs.gov/bni/)		
Expedited Determination Process Requirements FFS (traditional Medicare) Notice of Medicare Non-Coverage (NOMNC): CMS-10123 Detailed Explanation of Non-Coverage (DENC): CMS-10124	Providers are required to notify beneficiaries of their right to an expedited review of discharge of Medicare services. The NOMNC informs beneficiaries on how to request an expedited determination from their Quality Improvement Organization (QIO) and gives beneficiaries the opportunity to request an expedited determination from a QIO. The DENC is required when the beneficiary requests an expedited determination by the QIO (by noon of the day prior to LCD). DENC must be issued by the close of business of the day of the QIO notification. The QIO will review within 72 hours.	**Form CMS-10123** • Upcoming discontinuation of Medicare services, with benefit days remaining; Completed notice must be provided to beneficiary (or authorized representative) no later than 2 days before termination of services. No notice required when: • Benefit days have exhausted • Patient transferring to comparable provider • Leave of absence • Beneficiary decides to terminate services • Termination is for reasons other than medical necessity • Beneficiary requires higher level of care (ie. Transfer to acute care hospital) **Form CMS-10124** • Beneficiary appeals the decision for discharge • Must be issued by close of business on date of QIO notification. QIO will review in 72 hrs.
SNF ABN for part A Use form CMS-10055	Skilled Nursing Facilities (SNFs) must issue a liability notice to Original (fee for service) Medicare beneficiaries before the SNF provides: • 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 may use either the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) or one of the five SNF denial letters as the liability notice.	**Form CMS-10055 (or one of 5 SNF denial letters)** Beneficiary drops to a non-skilled level of care: • Benefits have not exhausted • Beneficiary remains in the facility (Medicare certified bed OR non-Medicare certified bed) • Services constitute custodial care • SNF feels Part A services are not medically reasonable and necessary