



Information for Healthcare Improvement



Expedited Appeal Connection

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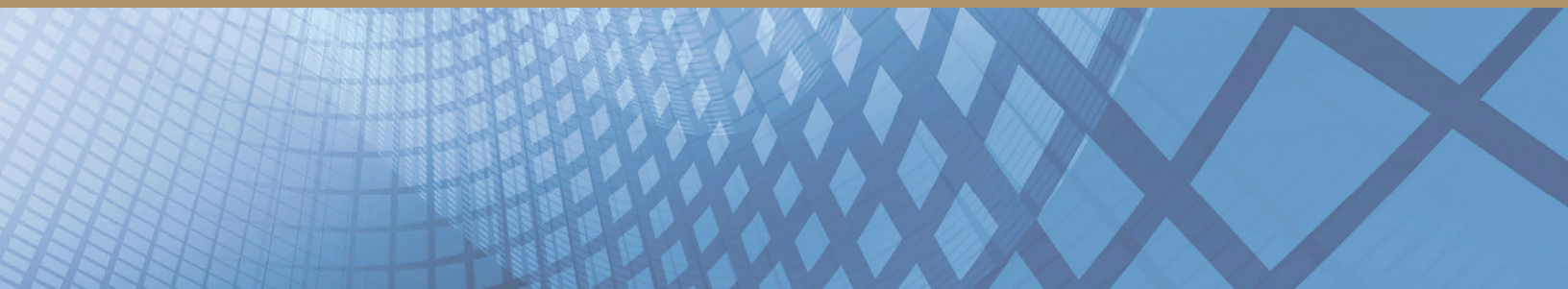
Notice of Medicare Non-Coverage (NOMNC)

As part of FMQAI's internal quality improvement efforts, a trend has been identified related to missing required elements on the Notice of Medicare Non-Coverage (NOMNC).

According to the Centers for Medicare & Medicaid Services (CMS), "*Medicare health plan enrollees receive a Notice of Medicare Non-Coverage (NOMNC) prior to (the) termination of Medicare-covered skilled nursing facility (SNF), home health (HH), and comprehensive outpatient rehabilitation facility (CORF) services. The NOMNC informs individuals of their right to an immediate, independent review of the proposed discontinuation of services....CMS regulations ensure that, when an enrollee challenges a plan termination decision, an independent review decision is made before the enrollee incurs liability*" (see http://www.cms.gov/BNI/09_MAEDNotices.asp).

In the instructions for the NOMNC, the Office of Management and Budget (OMB) states, "*...The name, address and telephone number of the plan or provider that actually delivers the notice must appear above the title of the form. The entity's registered logo is not required, but may be used. If the plan's name and contact information (are) not in the space above the title of the form, (they) must be displayed elsewhere on the form for the enrollee's use in case an expedited appeal is requested, or the enrollee or QIO seeks the plan's identification.*" (see <http://www.cms.gov/MMCAG/Downloads/NOMNCInstructions.pdf>).

Effective April 1, 2010, any and all NOMNC forms received in our office that do not include, at a minimum, the Medicare Advantage Organization's name will be determined to be invalid.



Power of Attorney

When issuing a Notice of Non-Coverage, facilities should keep in mind that the Notice must be given to a competent beneficiary. If there is doubt in the issuing person's mind regarding beneficiary competency, the issuer should ask his/herself, "Is this beneficiary able to exercise his/her right to an appeal?" In effect, can the beneficiary understand the notice, dial the telephone, and explain his/her point of view in a cogent manner? If the answer to any of these questions is "maybe" or "no," then the issuer should choose an alternative method of delivery of the Notice such as assisting the beneficiary in calling the QIO. If the beneficiary has a Health Care Surrogate or a Power of Attorney, that individual would be the person to receive the Notice. However, this is only if the beneficiary is incompetent as noted above. If a beneficiary is competent, then the beneficiary should receive the Notice regardless of Health Care Surrogacy or Power of Attorney.

If there is no Health Care Surrogate or Power of Attorney, the Notice cannot be given to an incompetent Beneficiary. In this instance, the issuer can, with the assistance of Social Services, seek a neutral party to act on the beneficiary's behalf. If this cannot be done, a Notice should not be issued.

In the instance where a Health Care Surrogate/Power of Attorney has been identified, only that person should be notified. The QIO will only speak with the person who calls for the appeal. In the instance where there is a Health Care Surrogate/Power of Attorney identified, that would be the person with whom the QIO communicates. There can be instances where the family members are in dispute with the Power of Attorney. This is a social issue and not one with which the facility or the QIO need become involved. In fact, communication with individuals other than the Health Care Surrogate/Power of Attorney could lead to questions of a HIPAA violation. If you need to issue a Notice and have questions concerning this process, please call the QIO and ask to speak to the Manager on Duty.



FAQs

Q. When does a skilled nursing facility need to issue both the Notice of Non-Coverage and the Advance Beneficiary Notice (ABN)?

A. Generally, there is no need to issue both at the same time. The only time both notices would be necessary is when all Medicare-covered services are ending, but the provider intends to deliver non-covered care. In this situation, the provider must issue the generic notice to advise that Medicare is discontinuing coverage and also give the beneficiary an ABN prior to starting non-covered care. By doing this, the beneficiary can make an informed choice as to whether to pay for these non-covered services or discontinue the services. If the facility does not provide the appropriate notice, the state surveyor will find the facility in violation of the notice requirements. This will lead to Cite tag F156, 42 C.F.R. 483.10, Resident rights.

Q. When is the Notice of Non-Coverage not required when ending Part B services in the skilled nursing facility?

A. The Notice of Non-Coverage does not need to be given with the following:

- Diagnostic x-ray tests;
- Diagnostic lab tests;
- Other diagnostic tests directly or under arrangement;
- Vaccinations or inoculations either directly or under arrangement;
- SNF providing leg, arm, back, neck braces, trusses, artificial legs, arms, or eyes, including adjustment, repair, and replacement required because of breakage, wear, loss, or change in physical condition either directly or under arrangement;
- SNF provided splints, casts, and other devices used for the reduction of fractures and dislocations either directly or under arrangement;
- SNF bills for rental or purchase of DME for use in the patient's home or place considered to be the residence either directly or under arrangement; and
- Exhaustion of Part B therapy caps.



*For more information about this newsletter or
for questions about the appeal process, contact:*

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*Remember, the educational trainings are still available
at <http://edu.flqio.org>. There is one Continuing
Education (CE) credit available for taking a course.*

This material was prepared by FMQAI, the Medicare Quality Improvement Organization for Florida, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. FL2010FONR211711