MDS Alert

Medicare: Untangle Misunderstandings About Changes In Medicare Non-Coverage

Check out expert clarification on facilities' responsibilities concerning noncoverage.

The Centers for Medicare and Medicaid (CMS) released the updates on letters for noncoverage back in April 2018, but lots of facilities are still confused about the changes.

Kris Mastrangelo, president and CEO of Harmony Healthcare International in Topsfield, Massachusetts, recently led a webinar, providing expert clarifications on what you need to know about Advance Beneficiary Notice of Non-Coverage (SNF ABN) And Notice of Medicare Non-Coverage (NOMNC).

What kind of notice?

On its website, CMS says, "Skilled Nursing Facilities (SNFs) must issue a notice to Original Medicare (fee for service - FFS) beneficiaries in order to transfer potential financial liability 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."

CMS requires facilities to give beneficiaries notice, via letter, before their Medicare coverage for skilled nursing care changes or ends. The system has been revised for 2018 to cut a bit of red tape for facilities while also providing beneficiaries with enough time and notice to figure out their care and payment.

The SNF ABN has recently been revised and requires facilities to use form CMS 10055, replacing the five denial notices and the SNF Notice of Exclusions from Medicare Benefits (NEMB) form (CMS 20014). The NEMB was used as a voluntary notice to inform beneficiaries of potential liability for items and services that are either subject to statutory denials or do not meet technical eligibility requirements, Mastrangelo says.

If this seems confusing, there's a reason! This is the third transition in method and means for notifying Medicare beneficiaries in the last 15 years, she says.

The NOMNC must be used for the generic notice, using CMS Form 10123. Your facility may need to provide this letter to residents regardless of whether their coverage is through Part A or Part B. The NONMC alerts beneficiaries that they have the right to appeal the facility's decision to a quality improvement organization (QIO), a third-party responsible for reviewing such decisions.

The NONMC generic notice should be given any time the facility believes Medicare will no longer pay for skilled service, Mastrangelo says. It should be delivered no later than two days before the date of end of coverage and must be completed by the facility and signed by beneficiary, she adds.

Note: The NONMC is appropriate only if the resident is a Medicare beneficiary who is to remain in your facility, she says.

Different for Medicare Part A versus Medicare Part B

Facilities need to know the different requirements for alerting residents who are Medicare Part A beneficiaries versus residents who are Medicare Part B beneficiaries.

Part A requires the SNF ABN, which uses the 2018 version of CMS form 10055. The SNF ABN is issued to "Medicare Part A

beneficiaries when they are being discontinued from their skilled benefit and they will remain in the facility when the facility determines that they do not meet the qualifications for skilled care," she says.

Part B requires facilities to fill out the Advance Beneficiary Notice (ABN), using CMS form CMS-R-131 (Exp. 03/2020), to alert Part B beneficiaries that certain items or services may be denied by Medicare paid under Medicare Part Band inform them of their potential liability. Mastrangelo notes the following particulars, for facilities sending out the ABN:

- "Not reasonable and necessary ('medical necessity') for the diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member (§1862(a)(1) of the Act); or
- "Custodial care ('not a covered level of care') (§1862(a)(9) of the Act).

Find links to both forms at the bottom of this story.

The ABN must be sent prior to the end of delivery of the care item or service in question. Facilities must provide enough time for the beneficiary to make an "informed decision on whether or not to receive the service or item in question and accept potential financial liability," she says.

When to provide which form

These forms must be signed by the beneficiary in acknowledgement that services or skills will not be covered by Medicare. "The beneficiary may say, 'This may not be reimbursable but I still want the services.' Signing means that if there's a dispute, you will not be liable for it," Mastrangelo says.

In the webinar, she provided this table, to help facilities understand which form is appropriate for which scenario.

Basically, your facility should give NOMCNC and SNF ABN at same time when denying Part A coverage if the resident still has Medicare-covered days available, and the resident is staying in facility, regardless of secondary payer source, she says.

"If they're in the building, and they have days available, you will give both letters," Mastrangelo says. This means the patient now has ability to appeal, as well as have a conversation about whether to continue the service.

Give only NOMNC when resident has skilled benefit days remaining and is being discontinued from Part A **and** leaving your facility.

Important: If the resident is a Medicare Part A beneficiary and appeals a decision to a QIO, the facility must continue to keep them on Part A until the case is determined, Mastrangelo says.

Routinely issuing the SNF ABN to any resident who's planning to return home, just in case she remains in your facility, is not required. "The team should maintain open communication with patients planning to return home. Team members should verify the delivery of the SNF ABN to patients who do remain in the facility after discontinuance of their skilled benefit, even if only for a few days after the originally planned discharge date."

Documentation and organization are key

Whenever your facility must send out any of these forms, getting the beneficiary's signature is super important because it releases your facility from liability, Mastrangelo says. The timeline for providing the notices of non-coverage is crucial as well because the resident must have time to appeal the decision.

Your team and facility should establish protocols to ensure that all i's are dotted and t's are crossed, including a policy for checking that all forms are signed and that any necessary copies are made.

Residents or legal representatives must sign notices to verify receipts, she says. If you cannot get the signature, document and provide a written notice of when any team member from your facility called or left a message.

Traditionally, if the facility has attempted contact through three phone calls and still hasn't reached the resident or her legal representative, the facility can then send a certified letter.

"You have to show the attempt of contact," Mastrangelo says. "The ultimate perfection is when you have the signature, date by beneficiary." The date(s) of telephone contact are helpful, as long as the decision of non-coverage is not disputed by beneficiary.

Rationale is important in appeal

If the situation arises where the beneficiary disagrees, she has the right to initiate an appeal.

In that case, the provider must give the beneficiary a second, more detailed notice (Detailed Explanation of Non-Coverage [DENC] CMS Form-10124) explaining reason for termination of coverage, Mastrangelo says.

"It's super important to detail the rationale for denial. Some of the simplest tasks become difficult in a time change," she says. In an appeal, the rationale for skilled coverage somewhere along the line has been overlooked or we are in the industry longer and are explaining what is skilled, she adds.

Communication is crucial, too

Remember that team members in certain roles may evaluate residents differently and determine, from the inherent differences in their professional perspectives, whether skilled care is still necessary. A nurse looks at a resident differently than a therapist. However, ensuring open communication within your team and with the resident's family may enable the facility to continue providing the same level of care, with the resident agreeing to assume financial liability.

"Don't underestimate value of a clinician coming in," Mastrangelo says. "The team has to look at service delivery and how is it being approached."

Resource: Find the correct form for SNFABN here: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html and for the CMS-R-131 here: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.