INSTRUCTIONS FOR DELIVERING A NOTICE OF MEDICARE NON-COVERAGE FORM (CMS-10123)

Remember to use the FLORIDA BLUE version of the Notice of Medicare Non-Coverage (NOMNC) form *for all of your Florida Blue Medicare Advantage (BlueMedicare[SM]) patients*. You can find the Florida Blue version on our website at floridablue.com; select Providers (top of the page), Tools & Resources, and then Forms.

The instructions below provide details on how to deliver the NOMNC form. A sample form follows the instructions to give you guidelines for completing our version of the form.

When to Deliver the NOMNC

- A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as "plans") must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.
- The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.
- Note: The two-day advance requirement is not a 48-hour requirement.
- This notice fulfills the requirement at 42 CFR 405.1200(b)(1) and (2) and 42 CFR 422.624(b)(1) and (2). Additional guidance for Original Medicare and Medicare Advantage can be found, respectively, at Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual.

Provider Delivery of the NOMNC

- Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual.
- A NOMNC must be delivered even if the beneficiary agrees with the termination of services.
- Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.
- The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.
- Electronic issuance of NOMNCs is not prohibited. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of electronic notice delivery.

Notice Delivery to Representatives

- CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative.
- Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact.
- If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered.
- The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt.
- Place a dated copy of the notice in the enrollee's medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the provider's mailing date.

Exceptions

The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

- When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).
- When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).
- When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).
- When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).
- When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).
- When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).
- When a provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

Please see a sample Florida Blue NOMNC form on the following pages.

SAMPLE

[Insert facility Logo and address]

Notice of Medicare Non-Coverage

Patient name: <<John Doe>> **Patient number:** <<SNF PT ID #>>

The Effective Date Coverage of Your Current <Insert Type of Service> Services Will End: <<This is the last covered day of service/day before discharge>>

Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current <insert type of service> services after the effective date indicated above.

- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO (KePRO) at 1-844-455-8708 or TTY/TDD 1-855-843-4776 to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: **Florida Blue For Fast Appeals ONLY: 1-877-842-9118, For Standard Appeals: 1-800-926-6565, OR TTY 1-800-955-8770.**

Additional Information (Optional):<<This space is to document telephone conversation with the AOR pursuant to 100-16, Chapter 13 Section 10.4.3. Telephone conversation must be dated/signed by staff. >>

<<If the Member/AOR refuses to sign the NOMNC, a note to that effect and the date of refusal must be documented here.>>

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

<<John Doe>>

Signature of Patient or Representative

Date << Must show a date of 2 days or more before the last covered day on front page>>

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-095

900-4159-0817