HAWAII HEALTH SYSTEMS C O R P O R A T I O N *"Touching Lives Everyday"* **Policies and Procedures**	***Quality Through Compliance***	**Policy No.:** **FIN 0007** **Revision No.:** N/A
	Issued by: Corporate Compliance Committee	**Effective Date:** December 5, 2001
Subject: ***Notice of Medicare Non-Coverage in a Skilled Nursing Facility***	**Approved by:** Thomas M. Driskill, Jr. President & CEO	**Supersedes Policy:** N/A **Page:** 1 of 6

I. PURPOSE: To establish procedural guidelines regarding the issuance of a "Notice of Medicare Non-Coverage" to the patient or representative prior to, or at, admission or when the type of care changes during a stay, that the care is non covered and the reason why the care is considered non covered.

II. POLICY: The appropriate Notice of Medicare Non-Coverage must be used whenever the Skilled Nursing Facility denies coverage based on Medicare benefit eligibility, medical necessity requirements, or when the patient's level of care is reduced.

III. PROCEDURE:

A. Determining Whether the SNF Had Knowledge of Non Coverage of Services. The SNF is considered not to have had knowledge of non-coverage of services in a particular claim unless there is evidence to the contrary. Such evidence may include the following:

1. Denial Rate Criterion - The SNF did not meet the criterion for a favorable presumption.

2. SNF Notices -

   - Your utilization review committee informed you in writing that the services were not covered;

   - You submitted a no-payment claim or claim for payment only at the request of the beneficiary;

   - You issued a written notice of non-coverage to the beneficiary.

3. HCFA Directives - HCFA has informed you in writing of the non coverage of a particular service or category of services.

4. Intermediary Notices -

   - A one-time written notice from the intermediary that a particular item or service is not covered (e.g., acupuncture) is sufficient notice for all subsequent claims involving that service.

   - The intermediary notified you by telephone and/or in writing that the care is not covered or that covered care has ended. If the beneficiary is still an inpatient, the intermediary gives you notice by telephone. The date of the telephone notice is the effective date of notification.

   - The intermediary issued a general provider bulletin or newsletter advising that a specific item or service is not considered reasonable and necessary.

5. Medical Information –

- A physician clearly indicated in the medical record that the patient no longer needed the services or the level of care provided;

- A physician indicated the patient could be discharged;

- The attending physician refused to certify or re-certify the patient's need for a level of care covered by Medicare because he determined that the patient does not require a covered level of care; or

- The physician explicitly stated that the patient was awaiting discharge or placement elsewhere.

6. Patently Unnecessary Services - An immediate finding of liability in fraud and abuse cases as well as in any other situation is made where you furnish and claim payment for services that are so patently unnecessary that you could reasonably be expected to know that they are not covered under Medicare.

B. Notifying Patient of Non Coverage.

1. If you are aware that the services to be furnished to a patient are not covered, advise the patient (or representative) in writing prior to, or at, admission (or when the type of care changes during a stay) that the care is non covered and why (see §§358ff.) and that no claim for Medicare reimbursement is being submitted.

2. If the beneficiary requests that you submit a claim, indicate on the bill that it is submitted at the beneficiary's request, and why you consider the care to be non-covered. Use the no-payment billing procedures.

3. Establish a procedure for notifying beneficiaries and physicians promptly when a decision of non-coverage is made. It must provide for the written notice of non coverage to the beneficiary or person acting on his behalf at admission or on the date you find the care to be non covered, or on the day the intermediary telephones a decision of non coverage to you.

C. Submission of Denial Notices in Which Demand Bills Are Requested. Submit to your intermediary, at the end of each calendar quarter, copies of all non covered notices to beneficiaries where you or the URC determined care to be non covered and the beneficiary or the representative requested that a demand bill be submitted. Attach beneficiary consent forms for admissions to non-certified beds.

D. Establishing When the Beneficiary is on Notice of Non-Coverage. If the beneficiary has previously been informed in writing that services were non-covered as a result of a prior stay for the same condition, the beneficiary is liable, but only if it is clear that the beneficiary (or the person acting on his behalf) knew that the circumstances were the same. With this exception, the beneficiary is presumed not to have known, nor to have been expected to know, that care is not covered unless or until one of the following occurs:

1. You are the Source of Notice -

   - You advised the beneficiary or the person acting on his behalf in writing on or before the day of admission that the care is non-covered.

   - During the patient's stay, the intermediary advised you that covered care has ceased and you notified the beneficiary or the person acting on his behalf in writing of the intermediary's determination.

   - During the inpatient stay, you advised the patient or the person acting on his behalf in writing that the patient no longer required covered care.

     NOTE: See §§358ff. For SNF Denial Letters to use to give notice of non-coverage to the beneficiary.

2. PRO Is Source of Notice - Where a beneficiary is in a swing-bed, the PRO notifies the beneficiary or the person acting on his behalf in writing that the care is not covered or it is no longer covered.

3. Intermediary Is Source of Notice - The beneficiary's first notification of non-coverage is received from the intermediary (e.g., intermediary denial notice).

4. UR Entity Is Source of Notice - The group or committee responsible for your UR notifies the beneficiary or the person acting on his behalf in writing that care is no longer covered.

E. Determining Date of Notice:

1. For Beneficiaries -

   a. In determining when the beneficiary received knowledge of non-coverage, the date of the written notice is used when the beneficiary is an inpatient and is capable of handling his own affairs (e.g., able to sign and negotiate checks).

   b. If you are unable to deliver the notice of non-coverage personally to a person acting on behalf of a beneficiary, telephone the person on the same day you know the services are not covered. Confirm the telephone contact by a written

notice mailed on that same date to protect yourself from liability. Mail the written notice even if a telephone contact cannot be made. Place a dated copy of the notice in the patient's medical file.

2. For SNFs -

   a. If you are notified of non coverage by an intermediary, use the date annotated in your records in accordance with §356D.

   b. Where you are notified of non-coverage by a URC, the intermediary uses the notice date shown by you on your bill, unless it has evidence of an earlier notification.

   c. Where you determine that covered care is no longer required, the intermediary uses the date of your written notice to the beneficiary.

F. Documentation of Notice: Retain copies of all notices of non coverage you give to beneficiaries because the date may be an important element in an appeal on the issue of limitation of liability and as evidence of notice for verification of resident's rights.

G. SNF Letters to Establish Beneficiary Notice of Medicare Non Coverage:

1. Use the following letters required by §357. Each letter includes the contents required for a beneficiary notice of non-coverage.

2. Where the PRO is not making utilization determinations about SNF care, use these letters. The letters notify the beneficiary of non-covered services.

   NOTE: These letters do not apply to swing bed determinations.

3. Make an original and two copies. (If the intermediary requires a copy, make one more copy.) Give, or where this is not possible, mail the original to the beneficiary (or person acting on his behalf). Send the first copy to the patient's attending physician, keep the second. When a copy is given to a beneficiary (or person acting on his behalf) keep a copy containing the signature of the beneficiary (or person acting on his behalf), and acknowledging the date the notice was received. Where personal delivery is not possible, your copy reflects the date the beneficiary was notified by telephone and the date the notice was mailed.

   a. Heading of Letter - Select the appropriate letter. (Refer to HCFA Pub 12 §358.2, Exhibits 1 to 5)

      (1) SNF Designation - Enter your name and address at the top.

      (2) Date Line - Enter the date you give or mail the letter to the beneficiary or his representative.

      (3) Addressee Line - Enter the name of the beneficiary (or the person acting on his behalf) and if the letter is mailed, the address of the beneficiary (or the person acting on his behalf). Position the name and address properly if a window envelope is used.

(4) Re Line - Where the letter is addressed to a person acting on behalf of the beneficiary, enter the name of the beneficiary. In all cases, however, enter the beneficiary's HICN and the date of admission.

b. Body of Letter - Complete as follows:

(1) Dates - Insert per instructions below for the appropriate letter.

(2) Reason Non-covered - Insert the specific explanation citing the medical facts in the case or select and insert the paragraph (see §§359 ff.) best describing the specific reason services are non-covered.

(3) Notification - Include all required notices. These are stated in the contents of each model letter.

c. Model Letters:

(1) Letter 1 - Use where you are advised of the non-coverage of services by your intermediary. Insert the date the covered care ended.

(2) Letter 2 - Use where you are advised by your URC that the stay was not medically necessary upon admission. Insert the date of the first day on which the stay is not medically necessary.

(3) Letter 3 - Use where the URC advises you that a further stay is not medically necessary. Insert the date of the first day on which the stay is not medically necessary.

NOTE: This notice is not a replacement for, but is in addition to, required URC notices. This notice protects you from liability in the event the beneficiary, for some reason, does not receive the URC notice.

(4) Letter 4 - Use where you determine prior to, or upon admission, that the services will not be covered.

(5) Letter 5 - Use where you determine that further services will not be covered. Insert the first day on which the services are not covered, usually the day following the date of the notice.

c. Phone Contact - Unsuccessful. An in-person or phone contact could not be made with the beneficiary or the person acting on behalf of the beneficiary. Mail the letter on the same day the contact was attempted. (See §357.1A.)

d. Signature of Administrative Officer - Your administrative officer or his agent signs.

e. Beneficiary Acknowledgements - Request for Medicare intermediary review:

- The beneficiary or the person acting on behalf of the beneficiary checks one of the boxes indicating whether or not he wants the bill to be submitted to the intermediary and signs the notice.

- Verification of Receipt - Complete the appropriate item to verify that notice of non-coverage was issued to the beneficiary or to the person acting on his behalf. (If the beneficiary or the person acting on his behalf refuses to sign the verification, annotate your copy of the letter accordingly. Indicate the circumstances and persons involved.)

H. SNF Denial Letters (copies attached) (Refer to HCFA Pub 12 Section 358.2):

1. EXHIBIT 1 - INTERMEDIARY DETERMINATION OF NONCOVERAGE
2. EXHIBIT 2 - UR COMMITTEE DETERMINATION OF ADMISSION
3. EXHIBIT 3 - UR COMMITTEE DETERMINATION ON CONTINUED STAY
4. EXHIBIT 4 - SNF DETERMINATION ON ADMISSION
5. EXHIBIT 5 - SNF DETERMINATION ON CONTINUED STAY

I. PAYMENT UNDER LIMITATION OF LIABILITY:

1. When it is determined that the beneficiary's stay is not covered but both you and the beneficiary are entitled to limitation of liability, the Medicare program may pay for the non covered services up to the date of notice and if you determine that more time is needed to arrange post-discharge care, for a grace period of l day (24 hours) after the date of notice to you or to the beneficiary, whichever is earlier. (See §§356 and 358 for definition of notice.) If it is determined that even more time is required in order to arrange post-discharge care, 1 additional "grace period" day may be paid for.

2. If you are given notice as described above, advise the beneficiary in writing of the determination made. Give your written notice to the beneficiary on the same date you receive notice from the intermediary. Where you fail to give the beneficiary such timely notice, the beneficiary is protected from liability until he receives the notice.

Exhibits:
1. Intermediary Determination of Noncoverage
2. UR Committee Determination of Admission
3. UR Committee Determination of Continued Stay
4. SNF Determination of Admission
5. SNF Determination on Continued Stay

EXHIBIT 1
INTERMEDIARY DETERMINATION OF NONCOVERAGE

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On *(date)*, the Medicare intermediary advised us that the services you receive will no longer qualify as covered under Medicare beginning *(date)*.

The Medicare intermediary will send you a formal determination as to the non-coverage of your stay after *(date)*. If you wish to appeal, the formal notice will contain information about how this can be done. The intermediary will inform you of the reason for denial and your appeal rights.

We regret that this may be your first notice of the non-coverage of services under Medicare. Our efforts to contact you earlier, in person or by telephone, were unsuccessful.

Please verify receipt of this notice by signing below.

Sincerely yours,

_____
(Signature of Administrative Officer)

- -

VERIFICATION OF RECEIPT OF NOTICE:
This acknowledges that I received this attached notice of non-coverage of services under Medicare on *(date of receipt)*.

_____
(Signature of Beneficiary or Person Acting on Beneficiary's Behalf)

- -

This is to confirm that you were advised of the non-coverage of the services under Medicare by telephone on *(date of telephone contact)*.

_____
(Name of Beneficiary or Representative Contacted)

_____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

EXHIBIT 2
UR COMMITTEE DETERMINATION OF ADMISSION

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On *(date)*, our Utilization Review Committee reviewed your medical information available at the time of, or prior to your admission, and advised us that the services *(you or beneficiary's name)* needed do not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason the services were determined to be non-covered.)

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request us to submit one. Furthermore, if you want to appeal this decision you must request that a bill be submitted. If you request a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination you may file an appeal.

You must also request that a bill be submitted to Medicare if you have questions concerning your liability for payment for the services you received.

Under a provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

We regret that this may be your first notice of the non-coverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
(Signature of Administrative Officer)

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

☐ I do want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: *(Name and address of intermediary)*.

☐ I do not want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

NOTE: Beginning October 1, 1989, you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

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VERIFICATION OF RECEIPT OF NOTICE

This acknowledges that I received the notice of non-coverage of services under Medicare on *(date of receipt)*.

_____

(Signature of Beneficiary or Person Acting on Beneficiary's Behalf)

This is to confirm that you were advised of the non-coverage of the services under Medicare by telephone on *(date of telephone contact)* .

_____

(Name of Beneficiary or Representative Contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

EXHIBIT 3
UR COMMITTEE DETERMINATION ON CONTINUED STAY

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On *(date)* our Utilization Review Committee reviewed your medical information and found that the services furnished *(you or beneficiary's name)* no longer qualified for payment by Medicare beginning *(date)*.

The reason for this is: *(Insert specific reason services were determined to be non-covered).*

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the covered services you received before *(date)*. Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision you must request that the bill submitted to Medicare include the services our URC determined to be non-covered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial or not reasonable or necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

We regret that this may be your first notice of the non-coverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want the bill for services after *(date)* submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

☐ I do want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be notified when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: *(Name and address of intermediary).*

☐ I do not want my bill for services submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

NOTE: Beginning October 1, 1989 you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

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VERIFICATION OF RECEIPT OF NOTICE

This acknowledges that I received this notice of non-coverage of services under Medicare on (date of receipt).

_____

(Signature of Beneficiary or Person Acting on Beneficiary's Behalf)

This is to confirm that you were advised of the non-coverage of the services under Medicare by telephone on (date of telephone contact).

_____

(Name of Beneficiary or Representative Contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

EXHIBIT 4
SNF DETERMINATION ON ADMISSION

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On *(date)*, we reviewed your medical information available at the time of or prior to your admission, and we believe that the services *(you or beneficiary's name)* needed did not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason services are determined to be non-covered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill be submitted to Medicare.

We regret that this may be your first notice of the non-coverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

☐ I do want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: *(Name and address of intermediary).*

☐ I do not want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if no bill is submitted.

NOTE: Beginning October 1, 1989 you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

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VERIFICATION OF RECEIPT OF NOTICE

This acknowledges that I received this notice of non-coverage of services under Medicare on *(date of receipt).*

_____

(Signature of Beneficiary or Person Acting on Beneficiary's Behalf)

This is to confirm that you were advised of the non-coverage of the services under Medicare by telephone on *(date of telephone contact).*

_____

(Name of Beneficiary or Representative Contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

EXHIBIT 5
SNF DETERMINATION ON CONTINUED STAY

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On *(date)*, we reviewed your medical information and found that the services furnished *(you or beneficiary's name)* no longer qualified as covered under Medicare beginning *(date)*.

The reason is: *(Insert specific reason services are considered non-covered.)*

This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the services you received before *(date)*. Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be non-covered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

We regret that this may be your first notice of the non-coverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

☐ I do want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: *(Name and address of intermediary).*

☐ I do not want my bill for services I continue to need to be submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

NOTE: Beginning October 1, 1989, you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

- -

VERIFICATION OF RECEIPT OF NOTICE

This acknowledges that I received this notice of non-coverage of services under Medicare on *(date of receipt).*

_____

(Signature of Beneficiary or Person Acting on Beneficiary's Behalf)

This is to confirm that you were advised of the non-coverage of the services under Medicare by telephone on *(date of telephone contact).*

_____

(Name of Beneficiary or Representative Contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS