Quartz

Instructions for Valid Delivery of the NOMNC for Skilled Nursing Facility

(Medicare Managed Care Manual Chapter 13, 10.4.3 - Notice Delivery to Representatives)

The CMS requires that notification of changes in coverage for an enrollee who is not competent be made to a representative of the enrollee. Notification to the representative may be problematic because that person may not be available in-person to acknowledge receipt of the required notification. Medicare health plans are required to develop procedures to use when the enrollee is incapable of receiving or incompetent to receive the notice, and the Medicare health plan cannot obtain the signature of the enrollee's representative through direct personal contact.

Regardless of the competency of an enrollee, if the Medicare health plan is unable to personally deliver a notice of non-coverage to a representative, then the Medicare health plan must telephone the representative to advise him or her when the enrollee's services will no longer be covered. The Medicare health plan must identify itself to the representative and provide a contact number for questions about the plan. It must describe the purpose of the call which is to inform the representative about the right to file an appeal. The information provided must, at a minimum, include the following:

- The date services end, and when the enrollee's liability begins;
- How to get a copy of a detailed notice describing why the enrollee's services are not being provided;
- A description of the particular appeal right being discussed (e.g., QIO vs expedited);
- When (by what time/date) the appeal must be filed to take advantage of the particular appeal right;
- The contact information for the entity who will process the appeal, including any applicable name, address, telephone number, fax number, or other methods of communication the entity requires in order to receive the appeal in a timely fashion;
- Provide at least one telephone number of an advocacy organization, or 1-800-MEDICARE that can provide additional assistance to the representative in further explaining and filing the appeal; and
- Additional documentation that confirms whether the representative, in the writer's opinion, understood the information provided.

The date the Medicare health plan conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

- Confirm the telephone contact by acknowledging the conversation in writing and mailing it on that same date.
- Place a dated copy of the notice in the enrollee's medical file and document the telephone contact with the member's representative (as listed above) on the notice itself.
- The documentation will indicate that the representative was informed of the date the enrollee's financial liability begins, the enrollee's appeal rights, and how and when to initiate an appeal.
- Also include the name, organization, and contact number of the staff person who made the contact.
- The name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

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 received.

Place a copy of the notice in the enrollee's medical file and document the attempted telephone contact to the members' representative.

The documentation will include: the name, organization, and contact number of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called.

When the return receipt is 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 Medicare health plan's mailing date. The form instructions accompanying a denial notice may also contain pertinent information regarding delivery to enrollees or their representatives. Medicare health plans and providers will consider such instructions as manual guidance.