Policy:	MA.6023
Title:	**Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	10/01/2005
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the procedure for delivery of the Notice of Medicare Non-Coverage (NOMNC) or Detailed Explanation of Non-Coverage (DENC) for a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF).

II. POLICY

A. A SNF, HHA, or CORF shall deliver a NOMNC to a Member receiving SNF, HHA, and CORF Covered Services before such Covered Services end in accordance with the terms and conditions of this policy.

B. CalOptima Health or a Health Network shall issue a Notice of Medicare Non-Coverage (NOMNC) to a Member receiving SNF Covered Services prior to the termination of such Covered Services, in accordance with this Policy.

1. The delegated Health Network shall:

   a. Notify the SNF; and

   b. Notify the CalOptima Health Long Term Services and Supports (LTSS) Department if a Member no longer meets the Medically Necessary criteria or has exhausted their Medicare SNF Covered Services by submitting a NOMNC as outlined in Section III.C of this Policy.

2. The issuing entity shall submit a fully completed and signed copy of a NOMNC consistent with the Centers for Medicare and Medicaid Services (CMS) NOMNC instructions to CalOptima Health's Utilization Management Department by fax prior to the close of business on the day the entity delivers the NOMNC to a Member, or Authorized Representative.

C. The issuing entity shall issue a Coverage Decision Letter instead of a NOMNC, if coverage is terminated for the following reasons:

1. Medicare benefit is exhausted;

2. Denial of Medicare admission;

3. Denial of non-Medicare Covered Services; or

4. Due to a reduction, or termination, of Medicare services that do not end the skilled Medicare stay.

D. The issuing entity shall issue at the Members request translated and /or large print notices as provided by CMS.

III. PROCEDURE

A. The SNF, HHA, or CORF is responsible for delivery of the NOMNC to the Member, or Authorized Representative.

1. The SNF, HHA, or CORF shall use the NOMNC Form No. CMS–10123.

a. The issuing entity shall deliver the NOMNC to a Member, or Authorized Representative, at least two (2) calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

b. The NOMNC may be delivered earlier if the date that coverage will end is known.

c. If the expected length of stay or service is two (2) days or less, the issuing entity shall provide notice upon admission.

2. The SNF, HHA, or CORF shall include the following Member-specific information on the NOMNC:

a. Member's name;

b. Delivery date of NOMNC;

c. Date that coverage of Covered Services ends; and

d. Quality Improvement Organization (QIO) contact information.

3. The SNF, HHA, or CORF shall send a NOMNC to a Member for whom Covered Services are ending, regardless of whether or not the Member agrees that such Covered Services should end.

B. The SNF, HHA, or CORF shall provide valid delivery of a NOMNC.

1. The Member or Authorized Representative shall sign and date the NOMNC to acknowledge receipt of the notice and comprehension of its contents.

2. The SNF, HHA, or CORF shall document the following:

a. If a Member or Authorized Representative refuses to sign the NOMNC, the SNF, HHA, or CORF shall document in the "Additional Information (Optional)" area

i. _____ or Authorized Representative refuses to sign
Member or Authorized Representative

the NOMNC on _____ at _____ _____
Date Time Representatives name and title

ii. The SNF, HHA, or CORF representative who attempted to deliver the NOMNC will sign as well, as a witness, if present at the time the Member, or Authorized Representative, refused to sign.

b. If a Member is physically unable to sign, requires the assistance of an interpreter to translate, or requires an assistive device to read or sign the NOMNC, the SNF, HHA, or CORF shall document the use of such assistance in the "Additional Information (Optional)" area.

c. If a Member is incompetent, or incapable, of receiving the NOMNC and the SNF, HHA, or CORF cannot obtain the Authorized Representative's signature through direct personal contact:

i. The SNF, HHA, or CORF shall contact the Authorized Representative by telephone and document the following on page three (3) Additional Information (Optional) of the NOMNC:

a) Name of person contacted;

b) Date of contact;

c) Time of contact; and

d) Signature of SNF, HHA, or CORF representative.

ii. Notification by certified mail must be followed by telephone notification. The following must be documented on page three (3) of the NOMNC:

a) Mailing address;

b) Date sent;

c) VIA: US Mail, Certified Mail, Priority Mail or FedEx; and

d) Tracking number (if applicable).

3. CalOptima Health, or the Member's Health Network, shall be financially responsible for continued Covered Services until two (2) calendar days after a Member receives a valid NOMNC.

4. A Member may waive continuation of Covered Services if they agree with being discharged sooner than two (2) calendar days after receiving notice.

C. If a Member no longer meets the Medically Necessary criteria or exhausts their Medicare SNF Covered Services, the Member may remain in the Facility under the CalOptima Health LTC Medi-Cal benefit, in accordance with CalOptima Health Policy GG.1822: Process for Transitioning CalOptima Health Members between Levels of Care.

D. If a Member does not agree that Covered Services should end, a Member may Appeal the termination decision, in accordance with CalOptima Health Policies MA.9004: Expedited Pre-Service Integrated Appeal, and MA.9008: Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services.

E. Upon notification by the QIO that a Member, or Authorized Representative, has requested an Appeal, CalOptima Health, or the Member's Health Network, shall issue a DENC to both the QIO and the Member, no later than the close of business of the day the QIO notifies CalOptima Health of the Appeal. The DENC shall contain:

1. The facts used to make the decision;

2. Why the service(s) are no longer covered, and the specific Medicare coverage rules and policy used to make this decision;

3. CalOptima Health's policy, provision, or rationale used in making the decision; and

4. A statement that informs the Member they have a right to request a copy of the policy or coverage guidelines used to make the decision, or a copy of the documents sent to the QIO, and a CalOptima Health contact number.

IV. ATTACHMENT(S)

A. Notice of Medicare Non-Coverage (NOMNC) Form No. CMS-10123
B. Notice of Medicare Non-Coverage (OneCare)
C. Notice of a Detailed Explanation of Non-Coverage
D. Coverage Decision Letter

V. REFERENCE(S)

A. CalOptima Health, Health Network Service Agreement
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Policy GG.1822: Process for Transitioning CalOptima Health Members between Levels of Care
D. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
E. CalOptima Health Policy MA.9008: Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services
F. Medicare Managed Care Manual, Chapter 13, Section 60.1 and 100.2
G. Title 42, Code of Federal Regulations (CFR.), §422.561, 422.624

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.6023	Notice of Medicare Non-Coverage	OneCare
Revised	05/01/2010	MA.6023	Notice of Medicare Non-Coverage	OneCare
Revised	11/01/2015	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare OneCare Connect
Revised	10/01/2016	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare OneCare Connect
Revised	10/01/2017	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare OneCare Connect
Revised	09/01/2019	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare OneCare Connect
Revised	10/01/2020	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare OneCare Connect
Revised	10/01/2021	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare OneCare Connect
Revised	12/31/2022	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare
Revised	12/31/2023	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare
Revised	12/01/2024	MA.6023	Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage	OneCare

IX. GLOSSARY

Term	Definition
Appeal	As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Authorized Representative	For the purposes of this policy, any individual authorized by a Member, or under state law, to act on their behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual.
Comprehensive Outpatient Rehabilitation Facility (CORF)	A Facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician.
Coverage Decision Letter	For integrated organization determination denials, applicable integrated plans must use the approved integrated denial notice, rather than the standard Integrated Denial Notice when issuing written denial notices to enrollees. The standardized integrated denial notice for applicable integrated plans is the Applicable Integrated Plan Coverage Decision Letter (Form CMS-10716), also known as the Coverage Decision Letter.
Covered Service	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Detailed Notice of Medicare Non-Coverage (DENC)	A document that includes a detailed explanation of why CalOptima Health determined that coverage for services currently being received should end. It is given to Members only when the Member requests an expedited Organization Determination.
Facility	For the purposes of this policy, may refer to a Long-Term Care (LTC) Facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B (NF-B) [Skilled Nursing Facility (SNF).
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Home Health Agency (HHA)	A public or private agency or organization that offers home care services including skilled nursing services and at least one other therapeutic service in the residence of the client through physicians, nurses, therapists, social workers, and homemakers whom they recruit and supervise.

Term	Definition
Integrated Appeal	Any of the procedures that deal with, or result from, adverse integrated organization determinations by CalOptima Health on the health care services the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services such that a delay would adversely affect the health of the Member, or on any amounts the Member must pay for a service.
Integrated Grievance	A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled nursing facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Medically Necessary or Medical Necessity	Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Medicare Non-Coverage (NOMNC)	A document that informs Members when their Medicare Covered Service(s) for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) is ending and how to request an expedited determination from their Quality Improvement Organization (QIO).
Organization Determination	Any determination made by CalOptima Health with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. CalOptima Health's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Reduction or premature discontinuation of a previously authorized service;

Term	Definition
	5. CalOptima Health's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing Facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital Facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
Skilled Nursing Facility (SNF)	A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.