LeadingAge Midwest
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F582 – Medicare & Medicaid Required Notices

F582 in Appendix PP requires that skilled nursing providers must:

Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing home and when the resident becomes eligible for Medicaid of

- The items and services that are included in nursing home services under the State plan and for which the resident may not be charged.
- Other items that are not included in the State plan for which the resident may be charged and the amount charged for those services and
- Inform each Medicaid-eligible resident when changes are made to the items and services offered.

Additionally, the nursing home must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the nursing home and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the per diem rate.

- Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, notice must be provided to residents as soon as reasonably possible.
- Where changes are made to charges for other items and services that the nursing home offers, notice must be provided at least 60 days prior to the implementation of the change.
- If a resident dies, is hospitalized, or transferred and does not return, the nursing home must refund to the resident, representative, or the estate, any deposit or charges already paid, minus the per diem rate for the days the resident actually stayed or reserved the bed, regardless of any minimum stay or discharge notice requirements within 30 days from the date of discharge.
- The terms of an admission contract by or on behalf of the individual seeking admission must not conflict with the requirements of the regulation.

While it isn't included in the regulatory language, the interpretative guidance lays out Medicare Beneficiary Notices that are required including the Notice of Medicare Non-Coverage (NOMNC) and the Advanced Beneficiary Notice (ABN).

The NOMNC or Form CMS-10123, is given by the nursing home to all Medicare beneficiaries at least **two days** before the end of a Medicare covered Part A stay or when all of Part B

therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization.

The interpretative guidance identifies that the NOMNC **is not** given if:

- The beneficiary exhausts skilled benefits coverage (100 days), thus exhausting their Medicare Part A Skilled Nursing Facility (SNF) benefit.
- The beneficiary initiates the discharge from the SNF.
- The beneficiary elects the hospice benefit or decides to revoke the hospice benefit and return to standard Medicare coverage.

The SNF ABN or CMS-10055, is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the nursing homes responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services. According to the SNF Medicare Claims Processing Manual, a SNF ABN must be given to the beneficiary for the following events:

- Initiation – in the situation in which the SNF believes Medicare will not pay for extended care items or services that a physician has ordered, the SNF must provide the ABN to the beneficiary before it furnishes those non-covered extended care items or services to the beneficiary.
- Reduction – In the situation in which a SNF proposes to reduce a beneficiary's extended care items or services because it expects Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide an ABN to the beneficiary before it reduces items or services.
- Termination – In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF must provide the ABN before it terminates the services.

Here is a link to the CMS website where the current SNF ABN and instructions are located: FFS SNF ABN | CMS

Here is a link to the CMS website where the current NOMNC and Detailed Explanation of Non-Coverage forms and instructions are located: FFS & MA NOMNC/DENC | CMS

This regulation is frequently cited when a provider fails to provide either the NOMNC and/or the SNF ABN notice, doesn't provide the notices at least two days before termination or reduction in services and/or areas on the forms are not completed.