PROVIDER TRAINING

NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

2015
NOMNC OVERVIEW

In this training module, you will learn about:

- What a Notice of Medicare Non-Coverage (NOMNC) is
- When you are required to deliver a NOMNC to a Medicare Advantage patient
- Which CareCentrix customers have Medicare Advantage plans
- Where NOMNC forms and instructions are located
- How you should complete the NOMNC form
- Where to obtain other information about NOMNC requirements
- NOMNC Do’s and Don’ts
The NOMNC letter is a Centers for Medicare and Medicaid Services (CMS) approved template letter.

You must not alter the NOMNC letter, and you must follow CMS instructions.

The NOMNC letter is intended to notify a Medicare member, in writing, that the member’s Medicare health plan and/or provider have decided to terminate the member’s covered Home Health Agency (HHA) care and, as a result of the termination of services, the member has appeal rights.

You are required to timely deliver a NOMNC to any Medicare Advantage patient discharged from home health care services unless a NOMNC exception applies (NOMNC Exceptions-Slide #5).

If a patient resides in a Medicare Advantage service area that meets CMS’ 5% foreign language threshold, the patient may request a NOMNC that is written in his/her own native language (Provider Resources: Slide #13).
NOMNC INFORMATION

- As of July 1, 2015, our Medicare Advantage Home Health customers include:
  - Horizon Blue Cross Blue Shield of New Jersey
  - Aetna
  - Florida Blue
  - Health Net

- Providers can easily identify a Medicare Advantage patient by looking on the Service Authorization Form (SAF).

- NOMNC letters and instructions are located on the CMS website. Remember that the OMB-approved NOMNC letter, form # CMS-10123, should be used in conjunction with the accompanying CMS instructions (Provider Resources: Slide #13).

- For Health Net of CA members only, providers must use Health Net’s pre-populated NOMNC letter containing the Quality Improvement Organization (QIO) contact information and other important information (Health Net Provider Resources: Slide 8-12).
NOMNC EXCEPTIONS

You are NOT required to deliver a NOMNC letter in these instances:

1. When a patient never received Medicare covered care in one of the covered settings.

2. When services are being reduced (i.e. a HHA providing physical therapy and occupational therapy discontinues the occupational therapy).

3. When a patient is moving to a higher level of care (i.e. home health care ends because a patient is admitted to a Skilled Nursing Facility (SNF)).

4. When a patient has exhausted his/her benefit.

5. When a patient ends care on his/her own initiative (i.e. patient decides to revoke the home health benefit and return to standard Medicare coverage).

6. When a patient transfers to another provider at the same level of care.

7. When a provider discontinues care for business reasons (i.e. HHA refuses to continue care at a home with a dangerous animal or because the patient was receiving physical therapy and the provider’s physical therapist leaves the HHA for another job).
GUIDELINES TO COMPLETE THE NOMNC FORM (PAGE 1)

**Contact information:** The name, address and telephone number of the provider that delivers the notice must appear above the title of the form. The provider’s registered logo may be used.

**Member number:** Providers may fill in the enrollee’s unique medical record or other identification number. Note that the enrollee’s HIC (Health insurance card) number must not be used.

**THE EFFECTIVE DATE YOUR (INSERT TYPE) SERVICES WILL END:** Insert Effective Date: Fill in the type of services ending, {home health, skilled nursing, or comprehensive outpatient rehabilitation services} and the actual date the service will end. Note that the date should be in no less than 12-point type. If handwritten, notice entries must be at least as large as 12-point type and legible.

**Bullet #4** Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type.
GUIDELINES TO COMPLETE THE NOMNC FORM (PAGE 2)

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: ________________________________

Additional Information (Optional):

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.

Signature of Patient or Representative ________________ Date ________________

Plan contact information: The plan’s name and contact information must be displayed here for the enrollee’s use in case an expedited appeal is requested or in the event the enrollee or the QIO seeks the plan’s identification.

OPTIONAL: Additional Information. This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as the Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.

Signature line: The beneficiary or the representative must sign this line.

Date: The beneficiary or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.
FOR HEALTH NET OF CA MEMBERS ONLY

- You must use one of Health Net’s 3 NOMNC letters. Each letter provides the specific Quality Improvement Organizations (QIO) address and phone number for that member’s plan as shown below.

- For the Dual Eligible/Medi Connect member’s NOMNC letter, you must also include Health Net’s Multi-Language Interpreter Service form*.

  - **Health Net Medicare HMO**
    - 1-800-275-4737
    - Health Net of California
    - PO Box 10344, Van Nuys, California 91410-0344

  - **Health Net Medicare PPO**
    - 1-800-960-4638
    - Health Net Life Insurance Co.
    - PO Box 10198, Van Nuys, California 91409-0198

  - **Health Net Dual Eligible**
    - 1-855-464-3571 (Los Angeles)
    - 1-855-464-3572 (San Diego)
    - Health Net Cal MediConnect Plan
    - 21281 Burbank Blvd, Woodland Hills, California 91367-6607

* Health Net’s Multi-Language Interpreter Service form (3 pages) must be provided along with the NOMNC letter.
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:
Health Net of California, Inc.
P.O. Box 10344
Van Nuys, California 91410-0344
Phone: 1-800-275-4737 TTY: 1-800-929-9955 or 711 National Relay Service
8:00 A.M. to 8:00 P.M. 7 days week

Additional Information (Optional):

[<<Provider/Facility>> <<Facility>> <<Service Start/Admission Date>> <<Date>>]
[<<Attending Physician>> <<Physician>>]

[<<Reason for discharge>>]

[<<For a Skilled Nursing Facility Stay Termination: The “Effective Date” shown on this notice is the last day your services are covered. The day that you leave, which is called the "date of discharge", is the day after the effective date. As long as you leave the facility the day after the "effective date" you will not have financial liability for any additional days.>>]

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.

Signature of Patient or Representative Date
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
Health Net Life Insurance Company
P.O. Box 10198
Van Nuys, California 91409-0198
Phone: 1-800-960-4638   TTY: 1-800-929-9955 or 711 National Relay Service
8:00 A.M. to 8:00 P.M. 7 days week

Additional Information (Optional):

<<Provider/Facility>> <<Facility>> <<Service Start/Admission Date>> <<Date>>
<<Attending Physician>> <<Physician>>

<<Reason for discharge>>

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Signature of Patient or Representative ___________________________ Date ________

Plan contact information: The plan’s name and contact information must be displayed here for the enrollee’s use in case an expedited appeal is requested or in the event the enrollee or the QIO seeks the plan’s identification. NOTE: This is different for all three Health Net NOMNCs. Please ensure you are providing the correct NOMNC for each patient.

OPTIONAL: Additional Information. This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as the Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.

Signature line: The beneficiary or the representative must sign this line.

Date: The beneficiary or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.
GUIDELINES FOR HEALTH NET OF CA
DUAL ELIGIBLE NOMNC (PAGE 2)

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
Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)
21281 Burbank Blvd.
Woodland Hills, CA 91367-6607
1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County)
TTY: 711 (National Relay Service)
24 hours, 7 days a week

Additional Information (Optional):

[<<Provider/Facility>> <<Facility>> <<Service Start/Admission Date>> <<Date>>
<<Attending Physician>> <<Physician>>]

[<<Reason for discharge>>]

[<<For a Skilled Nursing Facility Stay Termination: The “Effective Date” shown on this notice is the last day your services are covered. The day that you leave, which is called the “date of discharge”, is the day after the effective date. As long as you leave the facility the day after the “effective date” you will not have financial liability for any additional days.>>]

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.

Signature line: The beneficiary or the representative must sign this line.

Date: The beneficiary or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.

Additional Pages Needed: The 3 additional translation pages found with the Dual Eligible NOMNC are required to be given with the NOMNC. Link to this NOMNC can be found on slide 12.

Plan contact information: The plan’s name and contact information must be displayed here for the enrollee’s use in case an expedited appeal is requested or in the event the enrollee or the QIO seeks the plan’s identification. NOTE: This is different for all three Health Net NOMNCs. Please ensure you are providing the correct NOMNC for each patient.

OPTIONAL: Additional Information. This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as the Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.
HEALTH NET OF CA PROVIDER RESOURCES

Health Net NOMNC letters are to be used for Health Net patients only. A Health Net NOMNC letter is available with each SAF or on the sites below.

- Health Net of CA-HMO Medicare Advantage NOMNC Form:

- Health Net of CA-PPO Medicare Advantage NOMNC Form:

- Health Net of CA-Dual Eligible Medi Connect NOMNC Form:
  - [www.iceforhealth.net](http://www.iceforhealth.net), (click under Library, search for NOMNC for all approved ICE documents. Health Net NOMNCs are visible by plan name).
PROVIDER RESOURCES

- NOMNC letters and Instructions are located on the CMS website: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html.

- Quality Improvement Organizations (QIO) and related information are located at: www.qualitynet.org.
  - Under the Quality Improvement tab, under QIO Directories, then click on Beneficiary and Family-Centered Care (BFCC) QIOs.

- Provider Communications and Aids are available on our Provider Portal:
  - CareCentrix Provider Newsflash- April 2015.
  - CareCentrix Provider FAQ- April 2015.
  - Provider’s Dos and Don’ts (slide 14).
### PROVIDER DO’S & DON'TS

<table>
<thead>
<tr>
<th>Do:</th>
<th>Do NOT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Use the correct Form with 12 point font.</td>
<td>✗ Alter the NOMNC form in any way (i.e. shorten, abbreviate, or modified).</td>
</tr>
<tr>
<td>✓ Populate with accurate dates of service and provider demographics (i.e. name, address and telephone number of the provider).</td>
<td>✓ Shift letter text from page 1 to page 2 in order to accommodate a logo/header.</td>
</tr>
<tr>
<td>✓ Include the patient number.</td>
<td>✓ Populate with any wrong information.</td>
</tr>
<tr>
<td>✓ Document services and plan information clearly.</td>
<td>✓ Forget to obtain the enrollee’s signature and date on the form.</td>
</tr>
<tr>
<td>✓ Type or write the correct state Quality Improvement Organizations (QIO) information from <a href="http://www.qualitynet.org">www.qualitynet.org</a>.</td>
<td>✓ Delete any form language including the CMS form number and OMB control number.</td>
</tr>
<tr>
<td>✓ Deliver the form 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.</td>
<td>✓ Provide a form when an exception is met.</td>
</tr>
<tr>
<td>✓ Retain the original signed letter in the patient file.</td>
<td>✓ Forget to include patient representatives in the signing process as needed.</td>
</tr>
<tr>
<td>✓ Use the correct Form with 12 point font.</td>
<td>✗ Hesitate to obtain clarification if needed.</td>
</tr>
</tbody>
</table>
QUESTIONS?