Resident Rights Implementation Checklist (F582)

On June 29, 2022, the Centers for Medicare & Medicaid Services (CMS) updated Appendix PP of the State Operations Manual. New and revised guidance covers significant sections of the Requirements of Participation and must be implemented by October 24, 2022.

LeadingAge has developed implementation checklists to assist members as they work toward compliance. **The checklists and other resources are not exhaustive and LeadingAge strongly encourages members to review the CMS guidance to ensure compliance with all required elements.**

Excerpts from the guidance and suggested action items are organized according to the headings provided by CMS in the State Operations Manual, Appendix PP. Excerpts are italicized, with new/revised guidance noted in red text.

§483.10 Resident Rights – F582 Medicaid/Medicare Coverage / Liability Notice

GUIDANCE (p. 56)

New Guidance:

Beneficiary Notices

1. Notice of Medicare Non-Coverage (NOMNC)

The NOMNC, Form CMS-10123, is given by the facility 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. See also 42 CFR 405.1200 and 422.624.

*The NOMNC is **not** given if:*

- *The beneficiary exhausts the SNF benefits coverage (100 days), thus exhausting their Medicare Part A 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.*

Action Items:

- ☐ Develop/update policies and processes to ensure NOMNC Form CMS-10123 is provided to applicable Medicare beneficiaries at least 2 days before the end of a Medicare covered Part A stay or the end of Part B therapies.
- ☐ Audit records for Medicare Part A stays and Part B therapies that have ended since last survey for confirmation that NOMNC Form CMS-10123 was provided timely. Identify and address any barriers to providing timely notice.
- ☐ Train staff on providing NOMNC Form CMS-10123 within required timeframes to applicable beneficiaries and maintaining proof of timely notice.

New Guidance:

2. Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN)

It is important to note that the SNF ABN, 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 facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.*

Per Ch. 30, section 70.2 of the Medicare Claims Processing Manual (IOM Pub. 100-04), a SNFABN must be given to a beneficiary for the following triggering events:

- *Initiation - In the situation in which a SNF believes Medicare will not pay for extended care items or services that a physician has ordered, the SNF must provide a SNFABN 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 that 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 a SNFABN to the beneficiary before it reduces items or services to the beneficiary.*
- *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 a SNF ABN to the beneficiary before it terminates such extended care items or services.*

Action Items:

- ☐ Develop/update policies and processes to ensure SNF ABN Form CMS-10055 is provided to applicable beneficiaries prior to initiating, reducing, or terminating services that the

beneficiary intends to continue and the nursing home believes may not be covered by Medicare.

- ☐ Audit records for beneficiaries who received extended care items or services since last survey to determine if SNF ABN Form CMS-10055 was provided prior to initiating, reducing, or terminating services that were not covered by Medicare. Identify and address any barriers to providing notice.
- ☐ Train staff on providing SNF ABN Form CMS-10055 to beneficiaries prior to initiating, reducing, or terminating applicable services and maintaining proof of notice.

New Guidance:

The SNF:

- *Files a claim when requested by the beneficiary (this claim is called a "demand bill"); and*
- *May not charge the beneficiary for Medicare covered Part A services during demand bill process.*

For detailed information refer to the Medicare Claims Processing Manual (IOM Pub. 100-04) at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf. SNFABN is addressed in Ch. 30, section 70 of the manual and NOMNC is addressed in section 260.

NOTE: A facility's requirement to notify and explain via the SNF ABN that the individual is no longer receiving Medicare Part A services based on the SNF's belief that Medicare Part A will not pay for the resident's stay, is separate and unrelated to the admission and discharge requirements under 42 CFR §483.15, which outlines the notification and requirements under which an individual may be discharged from the facility or when the transfer or discharge is not initiated by the resident.

Action Items:

- ☐ Review policies and processes related to SNF ABN to ensure process exists for responding to and tracking demand bill requests.
- ☐ Train staff on filing and tracking demand bill claims.
- ☐ Audit records for beneficiaries who received extended care items or services since last survey to identify any requests for demand billing. Cross-reference with billing to ensure beneficiaries were not charged for Medicare covered Part A services during demand bill process.