Frequently Asked Questions: Notice of Medicare Non-Coverage

What is the Notice of Medicare Non-Coverage?
The *Notice of Medicare Non-Coverage (NOMNC)* is a notice that must be given to people with Medicare, or Medicare Advantage plan members, before the ending of all skilled services provided by skilled nursing facilities, home health agencies (including psychiatric home health), a comprehensive outpatient rehabilitation facility, or hospice services.

The notice is to let you know that you have the right to appeal the ending of your skilled services if you feel you need more care. The NOMNC explains your Medicare rights and gives instructions on how to begin your appeal. The provider must make every effort to make sure you understand the notice before getting your signature.

When will I get the Notice of Medicare Non-Coverage?
The NOMNC must be given at least two calendar days before Medicare-covered services end or the next to last day of service if care is not being provided every day, like home health services.

How do I know if I can ask for an appeal?
The Medicare provider is required, by law, to give you a NOMNC before ending your skilled services. Once you receive this notice, you can appeal that decision if you like.

***Who do I tell that I want to appeal the termination of my services*?**
A telephone or written request must be made to KEPRO, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) that works for Medicare to provide this service. KEPRO's telephone number is printed on the NOMNC and can also be found at www.keproqio.com. When you speak with the KEPRO staff, you will be asked "why" you believe you need to continue to receive skilled services. They will write down your reason and provide that, along with the medical information, to the physician reviewer. KEPRO is open every day of the year.

***What happens after I call KEPRO and ask for an appeal*?**
KEPRO will notify the provider of your appeal request and ask that your medical information be sent to them. The provider will securely send your medical information to KEPRO for review. The provider and/or Medicare health plan staff will give you the "Detailed Explanation of Non-Coverage" document that explains the reason they decided to end your skilled services.

KEPRO's physician reviewer will review the information and decide if the timing of the end of skilled services is appropriate. A decision of "agree with the end of skilled services" means KEPRO's physician reviewer agrees with the notice and that you are ready for a different level of care. A decision of "disagree with the end of skilled services" means KEPRO's physician reviewer does not agree with the notice and that you continue to require skilled care. KEPRO will call you with its decision within one day after receiving the necessary information.

***When should I request a discharge appeal*?**
If you would like to request a discharge appeal, contact KEPRO as soon as you can.

1. **"Timely Appeal":** If you make an appeal request to KEPRO no later than noon of the day before the Effective Date noted on the NOMNC.
2. **"Untimely Appeal":** If you do not make a timely appeal request and continue receiving skilled care, you still may request a review at any time, but you may be responsible for any charges after the Effective Date. If you have Medicare Advantage and make an untimely request, KEPRO will request a copy of the NOMNC in order to ensure that the notice itself is valid. If the NOMNC is valid, you will be directed to contact your plan for an expedited appeal.

When would I be financially responsible to pay the facility as part of the discharge appeal process?
Financial responsibility is determined by the timing of your appeal request:

- **Timely Appeal**
  - If KEPRO notifies you of a favorable decision of "disagree with the end of skilled services," you are not financially responsible for continued care (other than applicable coinsurance and deductibles) until the provider once again determines you no longer require skilled care and you receive another copy of the NOMNC.
  - If KEPRO notifies you of an unfavorable decision of "agree with ending of services," you are financially responsible for continued services the day after the Effective Date on the NOMNC.
  - If the review is not completed by the end of business on the Effective Date, you may have financial responsibility. Please know that residential facilities, such as skilled nursing, cannot charge the Medicare beneficiary for the day of admission AND the day of discharge. They can only charge one day or the other. If KEPRO provides you with a decision on the Effective Date, check with your Case Manager to determine when you might be charged for continued skilled services.
- **Untimely Appeal**
  - You may request a review at any time, but when you make an untimely appeal request and you remain in the facility, you may be held responsible for the charges incurred the day after the Effective Date on the NOMNC.
  - If KEPRO or your Medicare Advantage plan finds that you should have remained in the facility, the facility will refund you any money that was collected (other than applicable coinsurance and deductibles).
  - When you make an untimely discharge appeal request and are no longer receiving skilled care, you may still request a review within 30 calendar days of the date of discharge or at any time for good cause for financial liability issues.
- **Reconsideration**
  - If you are not in agreement with KEPRO's decision, you do have further appeal rights. These will be explained to you by KEPRO's staff when they call with the decision. If you don't understand, please ask them for further explanation.
  - If you file a reconsideration (second level of appeal) after your first appeal, you may stay in the facility, but you do not have any financial protection during this time frame and may be responsible for any continued skilled services charges until KEPRO contacts you with a decision. This reconsideration time frame may take up to 14 calendar days to complete.

What if I disagree with KEPRO's independent doctor's decision?
Medicare has five levels of appeals available to you. The five levels are outlined in the table below.

Appeal Level	Summary of Review Process	Who Performs the Review?
1st Level - Redetermination	Medical record review of the end of skilled services determination	Quality Improvement Organization (QIO) - KEPRO
2nd Level - Reconsideration	Medical record review of first level redetermination	KEPRO if you have a Medicare Advantage plan; Maximus or C2C if you have traditional Medicare
3rd Level - ALJ Hearing	Maybe an on-the-record review or an interactive hearing between parties	Administrative Law Judge
4th Level - Medicare Appeals Council Review	Medical record review of ALJ's decision or dismissal, but you may request oral arguments	Medicare Appeals Council
5th Level - Judicial Review	Judicial review	U.S. District Court

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