# F582 POLICY/PROCEDURE

**INTENT:**

It is the policy of the facility to notify the resident and or legal representative of Medicaid/Medicare Coverage/Liability in such a manner to acknowledge and respect resident rights.

# PROCEDURE:

The facility will:

1. Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of:
	1. The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged.
	2. Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.
2. Inform each Medicaid-eligible resident when changes are made to the items and

services.

1. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
	1. Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
	2. Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
	3. If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
	4. The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
	5. The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.

## The facility will provide the appropriate Notice(s) to a Medicare beneficiary as listed below:

1. Notice of Medicare Non-Coverage (NOMNC)

Facility will provide the NOMNC, Form CMS-10123, 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 will inform the beneficiaries of the right to an expedited review by a Quality Improvement Organization.

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

The facility will issue the SNF-ABN, CMS-10055, to a Medicare beneficiary if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. The facility will inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.

The SNF ABN provides information to beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility.

The facility will inform the beneficiary of his or her potential financial liability and related standard claim appeal rights.