KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Termination of Medicare Services IM, NOMNC, DND, DENC, CORF	**Policy #**	30.90-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	01/26/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

A. The Purpose of this Policy is to establish a mechanism for Kern Health Systems (KHS) in adherence to Centers for Medicaid and Medicare Services (CMS) which requires that all Medicare beneficiaries regardless of whether they agree with the decision will be issued a Notice of Medicare Non-Coverage (NOMNC), prior to discharge from Acute Care, Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), informing them that services could be safely rendered in another setting.

B. KHS shall ensure that all service determinations are appropriate and consistent with Centers for Medicare & Medicaid Services (CMS) requirements. KHS must work together to issue NOMNC letters to members who are being discharged from a SNF, HHA or CORF when services are ending. It is the SNF, HHA or CORF's responsibility to physically deliver the notice to the member within the required timeframes.

C. KHS's Registered Nurse (RN)(s) will monitor compliance with issuance of Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENCs) routinely. The recording of monitoring functions and outcomes will be made available to KHS in accordance with the delegation reporting directives and as part of the annual delegation audits conducted by KHS.

II. POLICY

A. KHS will abide by all CMS rules and requirements concerning notices of non-coverage for inpatient hospital care, skilled nursing, home health, and comprehensive outpatient rehabilitation facility, to include the additional rules that apply when a Medicare Advantage (MA) enrollee requests immediate Quality Improvement Organization (QIO) review of a determination that he or she no longer needs further care of the afore mentioned services.

III. DEFINITIONS

TERMS	DEFINITIONS
Compliance Authority	As applicable in context, all federal, state, and local laws, and regulations; accreditation standards and requirements; the Policies and Procedures ("P&Ps") are reviewed by the Medical Services Committee and adopted to meet contractual requirements.
Termination of Services.	The discharge of a member from covered provider services, or discontinuation of covered provider services, when the member has been authorized to receive an ongoing course of treatment from that provider.
Important Message (IM)	A hospital inpatient admission notice is given to all beneficiaries with Medicare, Medicare and Medicaid (dual-eligible), Medicare and another insurance program, Medicare as a secondary payer.
Notice of Medicare Non-Coverage (NOMNC)	The Notice of Medicare Non-Coverage (NOMNC) is a written notice designed to inform Medicare members that their covered skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) care is ending.
Detailed Notice of Discharge (DND)	The Detailed Notice of Discharge gives a detailed explanation of why the member's Medicare coverage for his/her hospital stay should end.
Detailed Explanation of Non-Coverage (DENC)	The Detailed Explanation of Non-Coverage (DENC) is a standardized written notice that provides specific and detailed information to Medicare members of why their covered SNF, HHA or CORF services are ending.
Comprehensive Outpatient Rehabilitation Facilities (CORF)	CORFs provide coordinated outpatient diagnostic, therapeutic, and restorative services, at a single fixed location, to outpatients for the rehabilitation of injured, disabled, or sick individuals. The Medicare beneficiary must have a medical need. A treatment plan has been established by a physician/ Non-Physician Practitioner (NPP) or by the therapist Outpatient Rehabilitation Facilities Physical therapy (ORF PT), Occupational Therapy (OT), Speech-Language

	Pathologist (SLP) services are rendered while the beneficiary is under the care of a physician.
Representative	A representative is defined broadly to include individuals authorized to act on behalf of the beneficiary; someone acting responsibly on behalf of an incapacitated or incompetent beneficiary; or someone requested by the beneficiary to act as his or her agent.
Termination of Services.	The discharge of a member from covered provider services, or discontinuation of covered provider services, when the member has been authorized to receive an ongoing course of treatment from that provider.
Important Message (IM)	A hospital inpatient admission notice is given to all beneficiaries with Medicare, Medicare and Medicaid (dual-eligible), Medicare and another insurance program, Medicare as a secondary payer.
Quality Improvement Organization (QIO)	Independent organization contracted by Centers for Medicare and Medicaid services to protect member rights, improve quality care, and ensure Medicare only pays for services that are reasonable and necessary in the most appropriate setting.

IV. PROCEDURE REQUIREMENTS

KHS designated staff perform concurrent reviews on all Acute SNF stays, HHA and CORF services.

When it is determined that the member is transitioning to a lower level of care (discharged) or authorized services are to be discontinued, the following Notification provisions shall be in place and followed.

A. Important Message

1. Hospitals must issue the Important Message for Medicare (IM) within two (2) days of admission and must obtain the signature of the beneficiary or his/her representative.

2. The original is given to the patient with a copy retained by the hospital.

3. Hospitals must also deliver a copy of the signed notice to each beneficiary not more than two (2) days before the day of discharge.

4. If the follow-up notice is delivered on the day of discharge, it must be given at least four (4) hours prior to discharge in consideration to their rights.

5. When a beneficiary is unable to understand the notice, the hospital may have the beneficiary's representative receive and sign the notice in accordance with state, federal, or other applicable law.
    a. If the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the beneficiary's rights as a hospital patient, including the right to appeal a discharge decision.

6. Beneficiary Refusal to Sign - If the beneficiary refuses to sign the notice, the hospital should note the refusal and date of refusal on the form, and this will be considered the date of notice.

7. The facility must document delivery of the notice to demonstrate compliance with the requirement.
    a. Hospitals should place a copy of the initial notice in the patient's medical record.
    b. Hospitals must document timely delivery of the follow-up copy of the IM in the patient's records, when applicable.
    c. The hospital should also document any attempted contact with beneficiary representatives, including telephone calls, messages and subsequent certified mail.

8. Follow-up notice is not required if delivery of the initial IM falls within two (2) calendar days of discharge, if the beneficiary is being transferred from one inpatient hospital setting to another inpatient hospital setting, or when a beneficiary exhausts Part A hospital days.

9. Hospitals must retain a copy of the signed notice.

B. Important Message Monitoring

1. KHS will require a copy of the Important Message to be submitted along with the member file for any member requesting an Appeal because they disagree with the termination of acute services/discharge notice (NOMNC).

2. The IM monitoring information by KHS shall be made available upon request or during KHS's annual delegation audit.

C. NOMNC

1. The Notice of Medicare Non-Coverage (NOMNC) is a written notice designed to inform Medicare members that their covered skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) care is ending.

2. The provider that delivers the NOMNC notice must list its contact information in the header section of the NOMNC Which includes the name, address and toll-free number of the provider.

3. The following steps are required to support the NOMNC notification process:
    a. KHS initiates the process to give the member a NOMNC letter no later than two (2) calendar days or two (2) visits before the proposed end of services is to occur.
    b. The member will be notified at the time of admission or upon the initiation of services if the services are expected to be fewer than two (2) calendar days or two (2) visits in duration.
    c. When the member is in a non-institutional setting, the notice must be delivered no later than the second-to-last time services are to be provided.

4. The NOMNC letter shall be completed according to CMS requirements and will include the following:
    a. The date that coverage of service ends,
    b. A determination that such services are no longer medically necessary,
    c. The date that the enrollee's financial liability for continued service begins,
    d. A description of the enrollee's right to a fast-track appeal,
    e. How to contact the Quality Improvement Organization (QIO),
    f. Description of the member's right to a fast-track appeal with the QIO,
    g. The enrollee's right to receive detailed information on why coverage is ending,
    h. Information on the availability of other Medicare appeal procedures if the enrollee fails to meet the deadline for a expedited determination when receiving care from a hospital, skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility.
    i. With respect to the applicability of the fast-track appeals process to situations involving the exhaustion of benefits, termination of services based on the exhaustion of Medicare benefits (Hundred (100) calendar days), per CMS directive, the Notice of Denial of Medical Coverage (NDMC) should be used to convey this information, rather than the NOMNC.
    j. KHS will adhere to Industry Collaboration Effort Utilization Management (ICE UM) timeliness standards for California (CA) Medicare Advantage

5. When a concurrent review is performed off-site, the facility staff will generate and issue the NOMNC.

6. Authorized representatives of incompetent members will be notified by telephone if personal delivery is not immediately available.

7. The telephone contact documentation requirements include the following:
    a. The notice contents will be covered with the representative,
    b. The conversation will be documented in the member's medical record,
    c. Confirmation of the telephone contact followed by a written notification mailed the same day.
    d. The date of the conversation is considered the date of receipt of the notice.

8. If the member disagrees with the termination of services/discharge:
    a. The member may contact the QIO, verbally or in writing, no later than noon of the day before the services are to end.

b. The member is entitled to wait until the last permissible day to submit a request for an appeal.
c. This is no later than noon the day before the effective date that Medicare coverage ends.

D. DND

1. KHS must deliver a completed copy of the DND notice to member or authorized representative upon notice from the Quality Improvement Organization (QIO) that the member or authorized representative has appealed a discharge from an inpatient hospital stay. The DND must be provided no later than noon of the day after the QIO's notification.

2. The DND notice must list the sender (KHS) contact information in the header section of the DND to include:
    a. The name, address and toll-free number of the provider.
    b. The member number may be a unique medical record or other provider-issued identification number; cannot use the Social Security Number (SSN) or Medicare Number.

    How to Complete DND:

    i. Complete Bullet # 1 The facts used to make the decision: Fill in patient specific information that describes the current functioning and progress of the beneficiary/enrollee with respect to the services being provided. Use full sentences, in plain language.

    ii. Complete Bullet # 2 The detailed explanation of why the services are no longer covered. Fill in the detailed and beneficiary specific reasons why the hospital stay is no longer reasonable or necessary for the beneficiary/enrollee or is no longer covered according to the Medicare guidelines. Describe how the beneficiary/enrollee condition does not meet these guidelines. Use full sentences, in plain language.

    iii. Complete Bullet # 3 policy, provision, or rationale used in the decision (MCG Guidelines). If the notice is delivered to a health plan enrollee: Fill in the reasons services are no longer covered according to the plan's policy guidelines, if applicable. Describe how the enrollee does not meet these guidelines.

        1) If a copy of the guideline is not sent, inform the members where and how they can get a copy.

        2) Provide the hospital/plan name and toll-free number for member or authorized representative to obtain a copy of the relevant documents sent to the QIO.

E. Expedited Review

1. A member has a right to request a review of the discharge decision, by asking for an expedited review by the QIO when the hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary.

2. The process is as follows:
    a. The member submits a request for review to the QIO no later than midnight of the day of discharge that has been ordered by the physician.
    b. The request may be in writing or by telephone and must be before the member leaves the hospital.
    c. If the request is not in this timeframe, and the member remains in the hospital, he or she may request a review at any time but will be held responsible for the charges incurred after the date of discharge ordered.
    d. If the QIO rules in favor of the member, the member's care will continue with no financial liability until the hospital once again determines that the member no longer requires inpatient care, secures the concurrence of the physician responsible for the member or the QIO and notifies the member with a follow-up copy of the IM.
    e. If the QIO does not agree with the member the liability for continued services begins at noon the day after the QIO notifies the member.

F. DENC PROCESS

1. A detailed notice of Non-Coverage is required when members are receiving covered skilled nursing, home health, and comprehensive outpatient rehabilitation facility are informed of the termination of services in these settings and in turn the Quality Improvement Organization (QIO) has been notified that the member or authorized representative has appealed. If after the member or member's representative is in receipt of the NOMNC and is requesting an appeal of the discontinuation, a Detailed Explanation of Non-Coverage (DENC) is required to be issued to the member.

2. The provider that delivers the DENC notice must list its contact information in the header section of the DENC Which includes the name, address, and toll-free number of the provider.

3. KHS is required to comply with delegation requirements regarding the preparation and issuance of the DENC to the members.

4. If the member requests an appeal on the same day the member receives the NOMNC, then KHS has until the close of business of the following day to submit the case file in collaboration as appropriate with the facility case manager.

5. Once a determination has been made to uphold or overturn the member's appeal request, the health plan and/or QIO will notify KHS of the decision.

6. If the decision is overturned by the QIO, KHS will do the following:
    a. Continue authorization to provider.

b. Prepare and issue a new NOMNC when new discharge orders are written.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other CMS, Department of Health Care Services (DHCS), and or Department of Managed Health Care (DMHC) guidance, including applicable All Plan Letters (APLs), Health Plan Management Systems (HPMS) memos, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

V. ATTACHMENTS

Attachment A:	
N/A	

VI. REFERENCES

Reference Type:	Specific Reference
Regulatory	Medicare Managed Care Manual Chapter 13, Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance, Section 100, 100.1, 100.1.1, 100.2, 100.2.1 https://www.cms.gov/medicare/appeals-grievances/managed-care/notices-forms
Other KHS Policies	KHS Integrated Expedited Appeals policy
Regulatory	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices Medicare/Medicare-General-Information/BNI/MOON
Regulatory	42 § 422.566 Organization Determinations
Regulatory	§ 405.1205 Notifying beneficiaries of hospital discharge appeal rights:

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy created to comply with Dual Eligible Special Needs Plan (D-SNP)	UM

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		