Department: Health Services Dept	**Number:** HS-008
Title: Facilities Determinations	
Original Effective Date: 1/1/2021	**Latest Revision Date: 12/30/2024**

PURPOSE:

To establish a standardized and comprehensive process for Sonder Health Plans ("SHP" or "the Plan") to manage appropriate authorization for facilities and associated services including adverse organization determinations related to facility discharges or denied coverage for continued stays in inpatient hospitals and post-acute care facilities. This policy further outlines procedures for communicating members' appeal rights, ensuring members understand their options to challenge discharge or coverage termination decisions and SHP's facilitation of members' request for an immediate review by a Beneficiary and Family Centered Care – Quality Improvement Organization ("BFCC-QIO" or "QIO") or for an expedited reconsideration with SHP if the deadline for a BFCC-QIO request is missed. This policy applies to all SHP Health Services Department ("HSD") Utilization Management (UM) staff, Case Managers, and any other relevant HSD personnel involved in member discharge and post-acute service determinations.

DEFINITIONS:

- **Adverse Determination**: A denial or limitation of a requested item, service, Part B Drug, or benefit based on medical necessity or coverage criteria. This includes the decision to deny a service or payment, in whole or in part, or discontinue/reduce a previously authorized or provided service.
- **Appeal:** A request by a member or member's authorized representative for reconsideration of an adverse determination.
- **Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO or QIO):** An independent organization that reviews Medicare beneficiary concerns about quality of care, including determinations related to premature discharges or denials of continued stays.
- **Enrollee/Member/Beneficiary:** In this document, enrollee, member, and beneficiary may be used interchangeably and refers to a Medicare Advantage eligible individual who has elected Sonder Health Plans to receive coverage and benefits.
- **Immediate Review:** An expedited review requested by a member through the BFCC-QIO to determine the appropriateness of discharge or denial of continued services.
- **Observation Services:** An "observation stay" is defined as a hospitalization up to and including 72 hours. At 72 hours, the Observation stay becomes defined as an "admission" and requires notification from the facility and authorization on a concurrent basis.
- **Reconsideration:** A review of adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit, or the MA organization or CMS obtains.
- **Retrospective Requests:** A retrospective request is any pre-service request for authorization that is submitted to SHP after services are rendered. If the request spans a time before and after it was received, the portion of the request prior to receipt is considered retrospective. For Inpatient services, a retrospective request is any request for authorization for a stay received more than one business day after the member discharges. In most circumstances, SHP does not authorize retrospective requests.
- **Skilled Services:** Services which the skills of a technical and/or health care professional such as

a registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, etc. Medical services must be delivered under the direct/general supervision of these skilled nursing or rehabilitation personnel to assure the safety of the member and to achieve the desired medical outcome.

POLICY STATEMENT:

SHP is committed to protecting its members' rights regarding facility discharge determinations and adverse decisions on continued coverage in hospitals and post-acute care settings. For purposes of this policy and consistent with CMS regulations set forth in §422.620, the term hospital is defined as any facility providing care at the inpatient hospital level, whether that care is short term or long term, acute or non-acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition also includes critical access hospitals.

Hospital and other inpatient facility services require authorization by the Plan. Services approved at a hospital or other inpatient facility will include payment for all approved services performed by the hospital and physicians. Payment will be made at negotiated rates or services rendered to any non-participating provider will be reimbursed at prevailing Medicare rates. Single Case Agreements may be implemented by the Provider Relations Department in conjunction with Health Services leadership. Covered Physician services, provided during the approved stay, will not require additional authorization for payment. The facility authorization will encompass all physician/provider services whether the provider is a network or non-network physician.

When a member disagrees with a decision involving discharge or continued stay for hospitals or designated post-acute care facilities, such as skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehab facilities (CORFs), they have the right to file an immediate review request with the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) while the service is ongoing. Alternatively, if the deadline for a BFCC-QIO is missed, members retain the right to request an expedited reconsideration directly with SHP, allowing for timely and appropriate handling of appeals in line with CMS guidelines.

PROCEDURES:

I. Initiation of Discharge Planning

A. **Early Initiation:** Attending/Treating physicians and UM staff are encouraged to initiate discharge planning at the time of admission to any inpatient or skilled facility. UM staff, in collaboration with the facility's care team, will assess the member's expected discharge needs, including home health services, medications, equipment, or transportation.

B. **Collaboration with Multidisciplinary Teams:** Discharge planning is coordinated with a multidisciplinary team, which may include physicians, nurses, case managers, social workers, physical therapists, and others as appropriate.

II. Daily Reviews

A. The SHP Health Services Department (HSD) must receive clinical information in a timely manner, as clinical documents are necessary for medical necessity review and managing a member's care though the continuum. Likewise, notification of a stay must be provided to SHP during the stay or within a business day to assure the appropriate level of care and services.

B. The UM staff will conduct ongoing reviews of the member's clinical status to ensure that care is progressing appropriately, and that discharge planning is on track.

C. An administrative denial may be issued to any institution who fails to submit an authorization request or adequate clinical information for services. When a facility fails to submit the clinical information necessary for a review, the Nurse Reviewer will request the

information on 3 separate occasions (days) and document the method the request for clinical information was sent in the Utilization Management System.

D. Untimely requests for authorization will receive a notice with instructions for the appeals process if the facility wishes to appeal the decision.

III. <u>Discharge Planning:</u>

A. Prior to any scheduled discharge, SHP staff may confirm the date and time of discharge with the facility liaison, facility case manager, or discharge planner to assist with coordination of post-discharge services.

B. SHP Staff may assist in coordinating any placement in any other necessary facility (SNF, rehabilitation facility, etc.) or home services with the member, family, primary care physician, admitting physician, facility case manager and/or the discharge planning staff.

C. ***Refer to HS-021: Discharge Planning Policy for additional guidance, including specific reporting requirements for DSNP members.***

IV. <u>Notification Forms Related to Hospital Discharges</u>

A. Hospitals (can include Long Term Acute Care Hospitals (LTACHs), Inpatient Rehabilitation Facilities (IRFs) and Behavioral Health Stays that include Room & Board- excludes Partial Hospitalization Programs (PHPs)}:

i. **Important Message from Medicare (IM):** Before discharge, hospitals are required to deliver the standardized form, CMS Form 10065 (formerly CMS-R-193) "Important Message from Medicare" (IM) within two (2) days of admission and again within two (2) calendar days of discharge. This notice informs members of their rights as a hospital inpatient, including their right to appeal an impending discharge.

ii. **Hospital-Issued Notices of Non-Coverage (HINNs):** If a hospital determines that an inpatient admission is not medically necessary or that inpatient coverage should end, it must issue an HINN to the member, per CMS guidelines.

1. There are several HINN forms. HINN-10 is usually used for Medicare Advantage members when a hospital determines that a beneficiary no longer needs inpatient care but is unable to obtain the agreement of the physician, and therefore requests a QIO review. Hospitals must notify the beneficiary that the review has been requested.

B. SHP Contracted Facilities**:** In cases where SHP intends to recommend discharging a member from a contracted facility or deny continued coverage, two (2) notices are required:

i. The SHP Contracted Facility Concurrent Inpatient Review Status Notification, and, if necessary,

ii. The Detailed Notice of Discharge (DND), Form CMS 10066, which is provided only if a member requests an appeal of the discharge.

C. **SHP: Non-contracted Facilities:** In cases where SHP intends to recommend discharging a member from a non- contracted facility or deny continued coverage, one (1) notice is required: the Detailed Notice of Discharge (DND), Form CMS 10066, which is provided only if a member requests an appeal of the discharge.

D. **Detailed Notice of Discharge (DND), Form CMS 10066**

i. Timing of Provision: If the member decides to request an immediate review, SHP must issue the DND upon notification from the BFCC-QIO of the appeal. The DND must be provided by noon of the day following the BFCC-QIO's notification to SHP.

ii. Purpose: The DND gives a more comprehensive explanation of the medical or other rationale behind the decision to discharge or end coverage.

iii. Contents: The detailed notice must include the following information:

1. **The facts used to make this decision.** SHP must document the 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.

2. **A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered.** SHP must provide 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.
3. **The SHP policy, provision, or rationale used in the decision** if the notice is delivered to a health plan enrollee. SHP to 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. If the plan relied exclusively on Medicare coverage guidelines, please explain that here. Use full sentences, in plain language.
4. **How to access guidelines or policies.** If the hospital or SHP has not provided the Medicare guidelines or policy used to decide the discharge date, inform the beneficiary/enrollee on how and where to obtain the policy. Provide the hospital name/plan name (SHP) and toll-free number for beneficiaries/enrollees to obtain a copy of the relevant documents sent to the QIO.

V. <u>Member's Right to Immediate Review of Impending Hospital Discharge</u>

A. A member has the right to request an immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization ("BFCC-QIO") when SHP or hospital (acting directly or through its utilization committee), with physician concurrence, determines that inpatient care is no longer necessary.
   i. To request a BFCC-QIO review (immediate review), the enrollee must follow the steps listed on the IM. The request must be made no later than the day of discharge and may be in writing or by telephone.
   ii. The enrollee, or his or her representative, upon request by the QIO, must be available to discuss the case. The enrollee may, but is not required to, submit written evidence to be considered by a QIO in making its decision.
   iii. An enrollee who makes a timely request for an immediate QIO review is subject to financial liability protections, meaning, SHP, not the enrollee, is financially liable for coverage of services during the QIO review.
   iv. When an enrollee does not make a timely request for an immediate QIO review, he or she may request an expedited reconsideration by SHP. The financial liability rules governing immediate QIO review would not apply to SHP in this scenario.
      1. SHP's Medical Director or his/her designee has 72 hours to make a decision regarding the expedited reconsideration.

B. SHP's Responsibility
   i. When a BFCC-QIO notifies SHP that an enrollee has requested an immediate review of a planned discharge, SHP must:
      1. Properly execute and deliver (directly or by delegation) a Detailed Notice of Discharge ("DND"), Form CMS-10066, to the member as soon as possible, but **no later than noon of the day after the BFCC-QIO's notification**.
      2. Ensure delivery of the DND, regardless of whether it has delegated that responsibility to its providers.
      3. At an enrollee's request, SHP must deliver to the enrollee a copy of any documentation that it sends to the BFCC-QIO, including written records of any information provided by telephone. This documentation must be delivered to the enrollee **no later than the close of business on the first day**

after the material is requested.

4. Provide, directly or by delegation, all information that the BFCC-QIO needs to make its determination, including copies of the IM and the DND (if applicable). This information must be delivered as soon as possible, but no later than noon of the day after the BFCC-QIO notifies SHP of the enrollee's request.
5. **Note:** The delegation of notice delivery or other functions is determined by the contract between SHP and its providers. The BFCC-QIO determines whether SHP and the hospital should make the information available by telephone or in writing.
6. **Burden of Proof:** When an enrollee (or his or her representative, if applicable) requests an immediate review by a QIO, the burden of proof rests with SHP to demonstrate that discharge is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies. As such, SHP should supply any and all information that the BFCC-QIO requires to sustain the organization's discharge determination.

C. Hospital's Responsibility:
   i. In response to a request from SHP, the hospital must supply all information that the QIO needs to make its determination, including a copy of the notices required by CMS.
   ii. The hospital must furnish this information as soon as possible, but no later than by close of business of the day SHP notifies the hospital of the request for information.
   iii. At the discretion of the QIO, the hospital must make the information available by phone or in writing (with a written record of any information not transmitted initially in writing).

D. BFCC-QIO Determination:
   i. When the QIO issues its determination, the QIO must notify the enrollee, SHP, the physician, and hospital of its decision by telephone, followed by a written notice that must include the following information:
      1. The basis for the determination; a detailed rationale for the determination; an explanation of the Medicare payment consequences of the determination and the date an enrollee becomes fully liable for the services; and, information about the enrollee's right to a reconsideration of the QIO's determination, including how to request a reconsideration and the time period for doing so.
   ii. Effect of an Expedited QIO Determination
      1. The QIO determination is binding upon the enrollee, physician, hospital, and SHP except in the following circumstances:
         a. *Right to request a reconsideration.* If the enrollee is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request a reconsideration according to the procedures for fast-track of appeals of service terminations to Independent Review Entities (IREs).
         b. *Right to pursue the standard appeal process.* If the enrollee is no longer an inpatient in the hospital and is dissatisfied with this determination, the enrollee may appeal to OMHA for an ALJ hearing, the Council, or a federal court.

VI. Coverage During QIO Expedited Review of Hospital Stay:

A. SHP is financially responsible for continued coverage of services **during** the BFCC-QIO review, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

B. If SHP initially authorized coverage of the hospital admission:
   i. When SHP determines that hospital services are not, or are no longer, covered AND

SHP initially authorized coverage of the inpatient admission directly or by delegation (or the admission constitutes emergency or urgently needed care), SHP continues to be financially responsible for the costs of the hospital stay when an immediate QIO review is filed by the member **until noon of the day after the QIO notifies the enrollee of its review determination**.

ii. *Exception:* SHP's financial liability related to this section of the policy would not be applicable if the member fails to make a timely BFCC-QIO request.

C. If SHP did not initially approve hospital admission:
   i. When SHP determines that hospital services are not, or are no longer, covered AND coverage of the hospital admission was never approved by SHP, or the admission does not constitute emergency or urgently needed, SHP is liable for the hospital costs only if it is determined on appeal that the hospital stay should have been covered under the MA plan.

D. The hospital may not charge SHP (or the enrollee) if:
   i. It was the hospital (acting on behalf of the enrollee) that filed the request for immediate QIO review; and
   ii. The QIO upholds the non-coverage determination made by the MA organization.

E. If the QIO determines that the enrollee still requires inpatient hospital care, the hospital must provide the enrollee with a notice consistent with the IM Notice when the hospital or SHP subsequently determines that the enrollee no longer requires inpatient hospital care.

F. If the hospital determines that inpatient hospital services are no longer necessary, the hospital may not charge the enrollee for inpatient services received before noon of the day after the QIO notifies the enrollee of its review determination.

VII. Skilled Nursing Facility (SNF), Home Health Agency (HHA), and Comprehensive Outpatient Rehabilitation Services (CORF)

A. When a member is within 2 calendar days of SNF, HHA, Hospice, or CORF services ending or the second to last day of service if care is not being provided daily, the facility, provider, or SHP must provide the member with a Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, before their services end. (Note: The two-day advance requirement is not a 48-hour requirement.)
   i. If home health services are being provided less frequently than daily, the notice must be delivered no later than the next to last visit before Medicare covered services end.
   ii. There is an accepted circumstance when the NOMNC may be delivered sooner than two days or the next to last visit before coverage ends. This exception is limited to cases where a beneficiary receiving home health services is found to no longer be homebound, and thus ineligible for covered home health care.

B. SNFs includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e., physical therapy, occupational therapy, and speech therapy).
   i. A NOMNC must be delivered by the SNF at the end of Part A stay or when all of Part B therapies are ending.

C. **Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123**
   i. The NOMNC informs beneficiaries of their discharge when their SHP covered services are ending. If the beneficiary is deemed legally incompetent, the notification should be made to an authorized representative. If the beneficiary is temporarily incapacitated, the notification can be given to a family member or close friend that the provider has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the notices described in this section.
   ii. A NOMNC should be delivered even if the beneficiary agrees with the termination of services.
   iii. It is typically issued by the facility or provider where the SHP member is receiving services. However, providers may formally delegate the delivery of the notices to

a designated agent such as a courier service.

iv. In situations where the decision to terminate covered services is not delegated to a provider by SHP, but the provider is delivering the notice, SHP must provide the service termination date to the provider at least two calendar days before Medicare covered services end.

v. The effective date on the NOMNC is always the last day beneficiaries will receive coverage for their services.

1. Beneficiaries have no liability for services received on this date but may face charges for services received the day following the effective date of the NOMNC for home health, hospice, and CORF services.
2. Because SNFs cannot bill the beneficiary for services furnished on the day of (but before the actual moment of) discharge, beneficiaries may leave a SNF the day after the effective date and not face liability for such services.

vi. The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

vii. Electronic issuance of NOMNCs is not prohibited. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred.

viii. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of electronic notice delivery.

ix. If the beneficiary refuses to sign the NOMNC the provider should annotate the notice to that effect and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the NOMNC remain entitled to an expedited determination.

VIII. Member's Right to Immediate Review of Impending SNF/HHA/CORF Discharge

A. An enrollee has the right to request an immediate review by the BFCC-QIO when a SNF, HHA, or CORF decides to terminate previously approved coverage (which includes an MA plan or contract provider directing an enrollee to seek care from a non-contract provider/facility).

B. Enrollees must request an immediate review, by telephone or in writing by noon of the first day after the day of delivery of the NOMNC (that is, by noon of the day before the effective date on the NOMNC).

i. If, due to an emergency, the IRE is closed and unable to accept the enrollee's request for a fast-track appeal, the enrollee must file a request by noon of the next day that the IRE is open for business.

C. If the enrollee misses the timeframe, the enrollee may request an expedited appeal from SHP.

D. SHP's Responsibility:

i. When the BFCC-QIO notifies SHP that an enrollee has requested an appeal, SHP must:

1. Properly execute and deliver (directly in person or by delegation, such as via use of a courier) a **Detailed Explanation of Non-coverage (DENC)**, **Form CMS-10124**, to the enrollee as soon as possible, but **no later than close of business of the day of the BFCC-QIO's notification** to SHP.

a. If the beneficiary is deemed legally incompetent, the notification should be made to an authorized representative. If the beneficiary is temporarily incapacitated, the notification can be given to a family member or close friend that the provider has determined

could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the notices described in this section.

b. The DENC must contain the following information: The facts specific to the beneficiary's discharge and provider's determination that coverage should end; a specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered; and a description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.

c. The DENC does not require a signature but should be documented in the event of a beneficiary's refusal to accept the notice upon delivery.

d. The DENC should be translated in Spanish if necessary.

2. Ensure delivery of the DENC, regardless of whether it has delegated that responsibility to its providers.

3. At an enrollee's request, SHP must deliver to the enrollee a copy of any documentation that it sends to the BFCC-QIO, including written records of any information provided by telephone. This documentation must be delivered to the enrollee **no later than the close of business of the first day after the documentation is requested**.

4. Provide, directly or by delegation, all information that the BFCC-QIO needs to make its determination, including copies of the notices sent to the enrollee, such as the NOMNC and DENC and medical records. This information must be delivered as soon as possible, but **no later than the close of business of the day the BFCC-QIO notifies SHP of the enrollee's request**.

5. **Note:** The delegation of notice delivery or other functions is determined by the contract between SHP and its providers. The BFCC-QIO determines whether SHP and the hospital should make the information available by telephone or in writing.

ii. Financial Responsibility: SHP is financially responsible for continued coverage of services during the BFCC-QIO review, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

E. Effect of an Expedited QIO Determination

i. The QIO determination is binding upon the enrollee, physician, facility, and SHP unless the member pursues an expedited reconsideration.

ii. Effect on Continuation of Care:

1. If the QIO decision extends coverage to a period where a physician's orders do not exist, either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care, providers cannot deliver care.

2. In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or State requirements that physician orders be required for a provider to deliver care.

3. If a QIO decision is favorable to the beneficiary and the beneficiary resumes covered services, a new NOMNC should be delivered if that care is later terminated, per the requirements of this section. If the beneficiary

again disagrees with the termination of care, a new request to the QIO must be made.

4. The QIO decision will affect the necessity of subsequent Advance Beneficiary Notice of Noncoverage (ABN) deliveries.

IX. SNF and HHA Services Not Eligible for Expedited Review

A. The following service terminations, reductions, or changes in care are not eligible for an expedited review. SHP should not deliver a NOMNC in these instances. Instead, if a member requests coverage in the following situations, SHP must issue the **CMS form 10003 - Notice of Denial of Medical Coverage**.

i. When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).

ii. When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).

iii. When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).

iv. When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).

v. When beneficiaries end care on their own initiative.

vi. When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

vii. When a provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

X. Documentation, Record Keeping, and Auditing

A. SHP staff will maintain detailed documentation of all adverse determinations, notices provided, and any subsequent appeals or BFCC-QIO reviews.

B. SHP staff will ensure records are stored in compliance with HIPAA, CMS, and SHP-specific record retention policies.

C. SHP staff, via Compliance or UM leadership or assigned designee, will conduct routine audits to ensure compliance with CMS requirements for adverse organization determinations and BFCC-QIO coordination.

D. Findings will be reported to senior management and corrective actions implemented as needed.

Attachment(s):

- Attachment 1 – List of Forms and Purpose

Statutory Reference(s):

Federal:

- 42 CFR §422.560 – Basis and Scope
- 42 CFR §422.561 – Definitions
- 42 CFR §422.562 – General Provisions
- 42 CFR §422.622 - Requesting Immediate QIO Review of the Decision to Discharge from the Inpatient hospital.
- 42 CFR §422.578 – Right to a Reconsideration
- 42 CFR §422.580 – Reconsideration Defined
- 42 CFR §422.596 – Effect of a Reconsidered Determination
- 42 CFR §422.626 – Fast-track Appeals of Service Terminations to Independent Review Entities (IREs)

- CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective July 19, 2024)
- CMS Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections

Contract Reference(s):

- Medicare Advantage D-SNP Health Plan Agreement Between Georgia Department of Community Health and Sonder Health Plans, Inc.

Form Reference(s):

- Important Message, Form CMS-10065-IM (Issued by the Hospital)
- Hospital-Issued Notices of Non-coverage (HINNs) (Issued by the Hospital)
- The Detailed Explanation of Non-coverage (DENC), Form CMS-10124
- The Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123
- The Detailed Notice of Discharge, Form CMS-10066

Related Policy(s):

- HS-029: Case Management
- HS-037 Organization Determinations
- HS-039: Extension of Organization Determinations

ATTACHMENT 1 – LIST OF FORMS AND PURPOSE

Notice	Medicare Program	Type of Notice	Provider Type	Purpose	Link to Notice
Hospital-Issued Notices of Non-coverage (HINNs)	FFS *HINN 10 may be used for MA	Financial Liability Notices	Hospitals	Issued in order to transfer financial liability to beneficiaries if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered in a specific case. There are currently four different HINNs.	HINNs (ZIP)
Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123)	FFS & MA	Expedited Determination Notices	HHAs, SNFs, Hospices, and CORFs	Informs beneficiaries of their discharge when their Medicare covered services are ending.	NOMNC, Form CMS-10123 (ZIP) NOMNC Form Instructions (PDF)
Detailed Explanation of Non-Coverage (DENC, Form CMS-10124)	FFS & MA	Expedited Determination Notices	HHAs, SNFs, Hospices, and CORFs	Given only if a beneficiary requests an expedited determination. Explains the specific reasons for the end of covered services.	DENC, Form CMS-10124 (ZIP) DENC Form Instructions (PDF)
Important Message from Medicare (IM, Form CMS-10065)	FFS & MA	Hospital Discharge Appeal Notices	Hospitals	Informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights.	IM, Form CMS-10065 (ZIP)
Detailed Notice of Discharge (DND, Form CMS-10066)	FFS & MA	Hospital Discharge Appeal Notices	Hospital or MA Plan	Given only if a beneficiary requests expedited review of a discharge decision. Explains the specific reasons for the discharge.	DND, Form CMS-10066 (ZIP)
Integrated Denial Notice (IDN, Form CMS-10003) * Also called the Notice of Denial of Medical Coverage/Payment Form (NDMCP)	MA	Denial Notices	Medicare Health Plans	Issued upon denial, in whole or in part, of an enrollee's request for coverage and upon discontinuation or reduction of a previously authorized course of treatment.	IDN, Form CMS-10003 (ZIP) IDN, Form CMS-10003 Spanish (ZIP) IDN Form Instructions (PDF)