SAN FRANCISCO HEALTH PLAN

CO-65 Medicare Notices for Discharge or Coverage Termination

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	7/8/2025	New Policy
Signed by: Steve O'Brien 60DFB20814944C4...	CMO	7/2/2025	

SFHP POLICY AND PROCEDURE

Medicare Notices for Discharge or Coverage Termination

Policy and Procedure Number:	CO-65
Department:	Clinical Operations
Accountable Lead:	Clinical Operations Policy Analyst
Lines of Business and Coverage Programs Affected:	☐Medi-Cal ☒Medicare Advantage D-SNP – effective 1/1/26 ☐Healthy Workers HMO ☐Healthy SF ☐City Option ☐ All lines of business and coverage programs as listed above

POLICY STATEMENT

This policy outlines the procedure for an inpatient facility to deliver written notification of a member's inpatient facility rights and discharge appeals rights. Inpatient facilities deliver the Important Message from Medicare (IM) Notice to a member receiving covered inpatient hospital services upon admission and before coverage termination.

This policy also outlines the procedure for a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) to deliver written notice of a member's last covered date and appeals rights. A SNF, HHA, or CORF shall deliver a Notice of Medicare Non-Coverage (NOMNC) to a member receiving covered services before coverage termination.

Members may appeal hospital discharge or a decision to end Medicare covered services to the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), Livanta. Refer to G&A Policies GA-07: Appeal Process for Member Discharge from Inpatient Facility and GA-08: Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services.

PROCEDURE

1. Inpatient Facility

An inpatient facility and San Francisco Health Plan (SFHP), with the treating physician's concurrence, shall determine when inpatient care is no longer medically necessary and

discharge the member from the inpatient facility. Inpatient facilities are responsible for delivering the Important Message from Medicare (IM) Notice.

Members have the right to appeal an inpatient facility discharge and request an immediate review. Upon QIO notification that a member, or a member's authorized representative, has requested an immediate review, SFHP shall directly, or by delegation, deliver a Detailed Notice of Discharge (DND) to the member as soon as possible, but no later than noon of the day after the QIO's notification. Refer to GA-07: Appeal Process for Member Discharge from Inpatient Facility.

Important Message from Medicare (IM) Notice: An inpatient facility shall distribute an IM Notice to inform the member of their inpatient facility rights and discharge appeals rights.

a. The inpatient facility shall include the following information on the IM Notice:
    i. Member's full name;
    ii. Identification number, other than a social security number, to identify the member;
    iii. Name of the Member's admitting physician;
    iv. Name and telephone number of the BFCC-QIO, Livanta, that the Member can contact to appeal a discharge;
    v. Name and telephone number of a contact person at the inpatient facility for the member to contact with questions regarding the IM Notice; and
    vi. Name of the inpatient facility, including the Medicare Provider identification number.
b. **Delivery of the initial IM Notice:**
    i. An inpatient facility shall deliver an initial IM Notice:
        1. At or near the Member's admission date, but no later than two (2) calendar days following the date the member was admitted into the inpatient facility; or
        2. During a preadmission visit, but not earlier than seven (7) calendar days prior to the date of the member's admission.
    ii. An inpatient facility shall deliver the initial IM Notice to the member in-person. If the member is incapable or incompetent, the IM Notice shall be delivered in-person to the member's authorized representative.
    iii. If the inpatient facility is unable to deliver the initial IM Notice in-person to a member's authorized representative, the inpatient facility shall contact the member's authorized representative by telephone to inform them of the member's inpatient facility rights and discharge appeal right. If both the inpatient facility and the member's authorized representative consent, the inpatient facility may send the IM Notice to the member's authorized representative through electronic mail or facsimile.
    iv. The inpatient facility shall obtain a signature and date on the initial IM Notice from the member or the member's authorized representative.

Prior to obtaining a signature and date, the inpatient facility shall make every effort to ensure that the member or the member's authorized representative comprehends the contents of the IM Notice and provide an opportunity for them to ask questions.

v. The initial IM Notice shall not be delivered to a member or the member's authorized representative during an emergency and shall be delivered once the member is medically stable.

vi. If the member or the member's authorized representative refuses to sign and date the initial IM Notice, the inpatient facility shall document and date the refusal. The date of refusal shall be considered the date of receipt of the initial IM Notice.

c. **Delivery of the follow-up copy of the signed IM Notice**

i. An inpatient facility shall deliver a follow-up copy of the signed IM Notice before the member's planned discharge date, but not more than two (2) calendar days before the discharge date.

ii. If an inpatient facility delivers the follow-up copy of the signed IM Notice to the member on the day of discharge, the inpatient facility shall allow the member, if needed, at least four (4) hours to consider his or her inpatient facility rights and discharge appeals rights. An inpatient facility shall not routinely deliver the follow-up copy of the signed IM Notice on the day of discharge.

iii. The inpatient facility shall document the delivery of the follow-up copy of the signed IM Notice.

iv. An inpatient facility shall not deliver a follow-up copy of the signed IM Notice if:

1. A member is being transferred from one inpatient facility to another inpatient facility with the same level of care; or
2. The member's planned discharge date is within two (2) calendar days after the member's admission date.

2. Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF)

Prior to receiving SNF, HHA, or CORF services, San Francisco Health Plan (SFHP) and the SNF, HHA, or CORF will collaboratively determine the medically necessary service duration. The approved duration, including the last covered Medicare day, is specified in the approval letter sent to the member and provider. The provider letter also includes instructions to deliver the Notice of Medicare Non-Coverage (NOMNC) to the member at least two (2) calendar days before Medicare covered services end or, when the provider believes additional services are medically indicated, to request an extension from SFHP.

The SNF, HHA, or CORF is responsible for delivery of the Notice of Medicare Non-Coverage (NOMNC).

Members have the right to appeal a decision to end Medicare covered services.

Upon notification by the QIO that a Member, or Authorized Representative, has requested an Appeal, SFHP shall directly, or by delegation, issue a Detailed Explanation of Non-Coverage (DENC) to both the QIO and the member, no later than the close of business of the day the QIO notifies SFHP of the Appeal. Refer to GA-08: Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services.

Notice of Medicare Non-Coverage (NOMNC): The SNF, HHA, or CORF shall use the NOMNC Form No. CMS–10123.

a. The SNF, HHA, or CORF shall include the following Member-specific information on the NOMNC:
    i. Member's name;
    ii. Delivery date of NOMNC;
    iii. Date that coverage of Covered Services ends; and
    iv. The BFCC-QIO, Livanta contact information.
b. **Delivery of the NOMNC:**
    i. The issuing entity shall deliver the NOMNC to a Member, or Authorized Representative, at least two (2) calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.
    ii. The NOMNC may be delivered earlier if the date that coverage will end is known.
    iii. If the expected length of stay or service is two (2) days or less, the issuing entity shall provide notice upon admission.
    iv. The SNF, HHA, or CORF shall send a NOMNC to a Member for whom Covered Services are ending, regardless of whether or not the Member agrees that such Covered Services should end.
c. **Valid Delivery of a NOMNC**:
    i. The member or authorized representative shall sign and date the NOMNC to acknowledge receipt of the notice and comprehension of its contents.
    ii. The SNF, HHA, or CORF shall document the following:
        1. If a member or authorized representative refuses to sign the NOMNC, the SNF, HHA, or CORF shall document and date the refusal in the "Additional Information (Optional)" area of the form.
        2. The SNF, HHA, or CORF representative who attempted to deliver the NOMNC will sign as well, as a witness, if present at the time the member, or authorized representative, refused to sign.
    iii. If a Member is physically unable to sign, requires the assistance of an interpreter to translate, or requires an assistive device to read or sign the NOMNC, the SNF, HHA, or CORF shall document the use of such assistance in the "Additional Information (Optional)" area.
    iv. If a member is incompetent, or incapable, of receiving the NOMNC and the SNF, HHA, or CORF cannot obtain the authorized representative's signature through direct personal contact:

1. The SNF, HHA, or CORF shall contact the authorized representative by telephone and document the following on page three (3) Additional Information (Optional) of the NOMNC:
    a. Name of person contacted;
    b. Date of contact;
    c. Time of contact; and
    d. Signature of SNF, HHA, or CORF representative.
2. Notification by certified mail must be followed by telephone notification. The following must be documented on page three (3) of the NOMNC:
    a. Mailing address;
    b. Date sent;
    c. VIA: US Mail, Certified Mail, Priority Mail or FedEx; and
    d. Tracking number (if applicable).

v. San Francisco Health Plan shall be financially responsible for continued covered services until two (2) calendar days after a member receives a valid NOMNC.

vi. A member may waive continuation of covered services if they agree with being discharged sooner than two (2) calendar days after receiving notice.

d. **Long-Term Care**: If a member no longer meets skilled care criteria or exhausts their Medicare SNF benefit limit, the member may be able to remain in the facility under SFHP's Long-Term Care Medi-Cal benefit, in accordance with CO-02 Skilled Nursing and Custodial Long-Term Care.

MONITORING

Clinical Operations educates facilities on Medicare notice requirements and makes requirement information available on www.sfhp.org. Clinical Operations may perform targeted or random audits to ensure the notice was delivered appropriately.

DEFINITIONS

Appeal: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

Authorized Representative: For the purposes of this policy, any individual authorized by a member, or under state law, to act on their behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual.

Comprehensive Outpatient Rehabilitation Facility (CORF): A Facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician.

Coverage Decision Letter: For integrated organization determination denials, applicable integrated plans must use the approved integrated denial notice, rather than the standard Integrated Denial Notice when issuing written denial notices to enrollees. The standardized integrated denial notice for applicable integrated plans is the Applicable Integrated Plan Coverage Decision Letter (Form CMS-10716), also known as the Coverage Decision Letter.

Covered Service: Those medical services, equipment, or supplies that San Francisco Health Plan is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

Detailed Notice of Discharge (DND): A standardized notice provided by hospitals to members who have requested an appeal of a hospital discharge decision, explaining why their hospital care is ending and outlining applicable Medicare coverage rules.

Detailed Notice of Medicare Non- Coverage (DENC): A standardized notice provided by SNF's, HHAs, or CORFs to members who have requested an expedited organization determination that includes a detailed explanation of why coverage for services currently being received should end.

Home Health Agency (HHA): A public or private agency or organization that offers home care services including skilled nursing services and at least one other therapeutic service in the residence of the client through physicians, nurses, therapists, social workers, and homemakers whom they recruit and supervise.

Important Message From Medicare (IM) Notice: A notice given by the hospital to a patient receiving Medicare health care benefits, within two (2) days of being admitted to the hospital, but not sooner than seven days prior to admission, and when the patient is going to be discharged, that explains the patient's rights and tells them how to ask for an expedited review of the discharge decision by the Quality Improvement Organization (QIO).

Notice of Medicare Non-Coverage (NOMNC): A document that informs Members when their Medicare Covered Service(s) for Skilled Nursing Facility (SNF), Home

Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) is ending and how to request an expedited determination from their Quality Improvement Organization (QIO).

Skilled Nursing Facility (SNF): A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

AFFECTED DEPARTMENTS/PARTIES

Delegated Groups
Delegation Oversight
Health Services – Clinical Operations
Network Providers
Operations – Marketing & Communications
Operations – Provider Network Operations
Operations – Grievance & Appeals

RELATED POLICIES & PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

CO-01Utilization Management Decision Letters
CO-02 Skilled Nursing and Custodial Long-Term Care Admissions
CO-67 Inpatient Authorizations
GA-07: Appeal Process for Member Discharge from Inpatient Facility
GA-08: Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services

REVISION HISTORY

Original Date of Issue: June 26, 2025
Revision Approval Date(s):

REFERENCES

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Sections 100.1, 100.1.1, 100.2, 100.2.1
Title 42, Code of Federal Regulations (CFR.), §422.561, 422.620, 422.624

APPENDIX

Notices Delivered by Facilities				
Type of Request	**Decision**	**Details**	**Important Message from Medicare (IM)**	**Detailed Notice of Discharge (DND)**
Hospital Discharge	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained.	Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within two (2) calendar days of admission to a hospital inpatient setting. 2) not more than two (2) calendar days prior to discharge from a hospital inpatient setting. SFHP or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a Member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	Hospitals must issue the IM within two (2) calendar days of admission, obtain the signature of the Member or their authorized representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than two (2) calendar days prior to discharge from an inpatient hospital. NOTE: Follow up copy of IM is not required: > If initial delivery and signing of the IM took place within two (2) calendar days of discharge. > When Member is being transferred from inpatient to inpatient hospital setting. > For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, Member must be given adequate time (at least several hours) to consider their right to request a QIO review.	Upon notification by the QIO that a Member or their authorized representative has requested an appeal, the SFHP or delegate must issue the DND to both the Member and QIO as soon as possible but no later than noon of the day after notification by the QIO. The DND must include: > A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. > A description of any applicable SFHP Medicare coverage rules, instructions, or other policy, including information about how the Member may obtain a copy of the Medicare policy from the SFHP. > Any applicable SFHP policy, contract provision, or rationale upon which the discharge determination was based. >Facts specific to the Member and relevant to the coverage determination sufficient to advise the Member of the applicability of the coverage rule or policy to the member's case. > Any other information required by CMS.

Termination of Provider Services: • Skilled Nursing Facility (SNF) • Home Health Agency (HHA) • Comprehensive Outpatient Rehabilitation Facility (CORF)	SFHP or delegate is responsible for making the decision to end services	SFHP or delegate is responsible for making the decision to end services no later than two (2) calendar days or two (2) visits before coverage ends: > Discharge from SNF, HHA or CORF services, or > A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the Member or their authorized representative. > The NOMNC must be delivered no later than two (2) calendar days or two (2) visits prior to the proposed termination of services and must include: Member name, delivery date, date that coverage of services ends, and QIO contact information. > The NOMNC may be delivered earlier if the date that coverage will end is known. > If expected length of stay or service is two (2) days or less, give notice on admission.	Upon notification by the Quality Improvement Organization (QIO) that a Member or authorized representative has requested an appeal: SFHP or delegate must issue the DENC to both the QIO and Member no later than close of business of the day the QIO notifies SFHP of the appeal.