F582

(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)

§483.10(g)(17) The facility must—

- **(i) 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—**
  - **(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;**
  - **(B) 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; and**
- **(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.**

§483.10(g)(18) The facility must 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.

- **(i) 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.**
- **(ii) 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.**
- **(iii) 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.**
- **(iv) 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.**
- **(v) 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.**

DEFINITIONS §483.10(g)(17)-(18)

"**Periodically**" means whenever changes are being introduced that will affect the resident's liability and whenever there are changes in services.

GUIDANCE §483.10(g)(17)-(18)

Residents must be told in advance when changes will occur in their bills. Providers must fully inform the resident of services and related changes.

A Medicare beneficiary who requires services upon admission that are not covered under Medicare may be required to submit a deposit provided the notice provisions of §483.10(g)(17) if applicable, are met. Facility staff must notify residents of services or items that they may be charged for, if they are not required by the resident's care plan, such as hair salon services beyond basic services or incontinence briefs the resident requests per personal preference in lieu of the briefs provided by the facility. See §483.10(f)(11) for those items and services that must be included in payment under skilled nursing and nursing facility benefits.

The facility's responsibility regarding refunds applies to all residents for "any deposit or charges already paid" by a resident during their nursing home stay. For residents residing in a Continuing Care Retirement Community (CCRC), an exception can be considered for those residents who were admitted to the CCRC's nursing home, had deposits and charges related to the CCRC separate from those incurred during the nursing home stay, and who were discharged/transferred from the nursing home back to the same CCRC's independent or assisted living residences.

Beneficiary Notices

1. *Notice of Medicare Non-Coverage (NOMNC)*
   The NOMNC, Form CMS-10123, is given by the facility 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 informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization. See also 42 CFR 405.1200 and 422.624.

   *The NOMNC is **not** given if:*

   - *The beneficiary exhausts the SNF benefits coverage (100 days), thus exhausting their Medicare Part A SNF benefit.*
   - *The beneficiary initiates the discharge from the SNF.*
   - *The beneficiary elects the hospice benefit or decides to revoke the hospice benefit and return to standard Medicare coverage.*

2. *Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN)*
   It is important to note that the SNF ABN, CMS-10055, is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare.*It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.*

   Per Ch. 30, section 70.2 of the Medicare Claims Processing Manual (IOM Pub. 100-04), a SNFABN must be given to a beneficiary for the following triggering events:

   - *Initiation - In the situation in which a SNF believes Medicare will not pay for extended care items or services that a physician has ordered, the SNF must provide a SNFABN to*

the beneficiary before it furnishes those non-covered extended care items or services to the beneficiary.

- *Reduction - In the situation in which a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it reduces items or services to the beneficiary.*

- *Termination - In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF must provide a SNF ABN to the beneficiary before it terminates such extended care items or 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. If the SNF provides the beneficiary with *the* SNF ABN, the facility has met its obligation to inform the beneficiary of his or her potential *financial* liability and related standard claim appeal rights.

The SNF:

- *Files a claim when requested by the beneficiary (this claim is called a "demand bill"); and*
- *May not charge the beneficiary for Medicare covered Part A services during demand bill process.*

For detailed information refer to the Medicare Claims Processing Manual (IOM Pub. 100-04) at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf. SNFABN is addressed in Ch. 30, section 70 of the manual and NOMNC is addressed in section 260.

***NOTE**: A facility's requirement to notify and explain via the SNFABN that the individual is no longer receiving Medicare Part A services based on the SNF's belief that Medicare Part A will not pay for the resident's stay, is separate and unrelated to the admission and discharge requirements under 42 CFR§483.15, which outlines the notification and requirements under which an individual may be discharged from the facility or when the transfer or discharge is not initiated by the resident.*

KEY ELEMENTS OF NONCOMPLIANCE §483.10(g)(17)-(18)

To cite deficient practice at F582, the surveyor's investigation will generally show the facility failed to do one or more of the following:

- Notify each Medicaid- eligible resident in writing of the items and services which are/are not covered under Medicaid or by the facility's per diem rate, including the cost of those items and services:

- At the time of admission,**or**
- When the resident became eligible for Medicaid,**or**

- Inform each Medicaid-eligible resident when changes were made to the items and services covered by Medicaid;**or**
- Inform each resident of services available in the facility and the charges for those services not covered under Medicare/Medicaid or by the facility's per diem rate:
  - Before admission or at the time of admission, and periodically during the resident's stay;**or**
  - As soon as reasonably possible when a change in coverage occurs;**or**
  - At least 60 days prior to implementation of changes made to charges for other items and services that the facility offers;**or**
- Refund the applicable funds to the resident, resident representative, or estate when a resident died, or was hospitalized, or was transferred and did not return to the facility;**or**
- Refund any and all funds due the resident:
  - Within 30 days from the date of discharge;**or**
  - To the resident or resident representative;**or**
- Included terms in the admission contract that conflicted with the requirements of these regulations.