Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123

When to Deliver the NOMNC

A Medicare provider or health plan (Medicare Advantage plans and cost plans , collectively referred to as "plans") must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Note: The two day advance requirement is not a 48 hour requirement.

This notice fulfills the requirement at 42 CFR 405.1200(b)(1) and (2) and 42 CFR 422.624(b)(1) and (2). Additional guidance for Original Medicare and Medicare Advantage can be found, respectively, at Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual.

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

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

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.

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. 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.

Notice Delivery to Representatives

CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered.

The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the enrollee's medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the provider's mailing date.

Exceptions

The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

- 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).

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

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

- 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).

- When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).

- 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).

- 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).

Plans Only:

If a member requests coverage in the above situations, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage.

Alterations to the NOMNC

The NOMNC must remain two pages. The notice can be two sides of one page or one side of two separate pages, but **must not** be condensed to one page.

Providers may include their business logo and contact information on the top of the NOMNC. Text may not be moved from page 1 to page 2 to accommodate large logos, address headers, etc.

Providers may include information in the optional "Additional Information" section relevant to the beneficiary's situation.

Note: Including information normally included in the Detailed Explanation of Non-Coverage (DENC) in the "Additional Information" section does not satisfy the responsibility to deliver the DENC, if otherwise required.

Heading

Contact information: The name, address and telephone number of the provider that delivers the notice must appear above the title of the form. The provider's registered logo may be used.

Member number: Providers may fill in the beneficiary's/enrollee's unique medical record or other identification number. The beneficiary's/enrollee's HIC number must not be used.

THE EFFECTIVE DATE YOUR {INSERT TYPE} SERVICES WILL END: {Insert Effective Date}: Fill in the type of services ending, **{home health, skilled nursing, comprehensive outpatient rehabilitation services, or hospice}** and the actual date the service will end. Note that the date should be in no less than 12-point type. If handwritten, notice entries must be at least as large as 12- point type and legible.

YOUR RIGHT TO APPEAL THIS DECISION

Bullet # 1 not applicable

Bullet # 2 not applicable

Bullet # 3 not applicable

Bullet # 4 not applicable

Bullet # 5 not applicable

HOW TO ASK FOR AN IMMEDIATE APPEAL

Bullet # 1 not applicable

Bullet # 2 not applicable

Bullet # 3 not applicable

Bullet # 4 Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than12-point type.

Signature page:

Plan contact information (Plans only): The plan's name and contact information must be displayed here for the enrollee's use in case an expedited appeal is requested or in the event the enrollee or QIO seeks the plan's identification.

Optional: Additional information. This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as a

Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.

Signature line: The beneficiary/enrollee or the representative must sign this line.

Date: The beneficiary/enrollee or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.

write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.