

## DETAILED EXPLANATION OF NON-COVERAGE

### Form Instructions for the Detailed Explanation of Non-Coverage (DENC) CMS-10095

A Medicare health plan (“plan”) must provide a completed copy of this notice to enrollees receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings. This notice fulfills the requirement at 42 CFR 422.626(e)(1), and must be **provided no later than close of business of the day of the QIO’s notification.**

**Do not use the DENC if coverage is being terminated for any of the following reasons:**

- **Because the Medicare benefit is exhausted;**
- **For denial of Medicare admission to a skilled nursing facility or comprehensive outpatient rehabilitation facility or denial of coverage of Medicare home health services;**
- **For denial of non-Medicare covered services; or**
- **Due to a reduction or termination of a Medicare-covered service that does not conclude the skilled Medicare stay.**

**In these cases, the plan must issue the CMS form 10003 – Notice of Denial of Medical Coverage (NDMC).**

**The DENC is a standardized notice. Plans may not deviate from the wording or content of the form except where indicated authorized to do so.** Please note that the OMB control number must be displayed ~~on~~ in the upper right of the notice. Notice entries may be typed or handwritten. Handwritten entries must be at least as large as 12-point type and legible.

#### **Heading**

**Insert ~~logo~~ contact information here:** The name, address and telephone number of the plan or the provider that actually delivers the notice must appear above the title of the form. The entity’s registered logo is not required, but may be used.

**Date:** Fill\_ in the date the notice is generated by the plan.

**Patient Name:** Fill\_ in the enrollee’s ~~full~~ first and last name.

**Member number:** Fill\_ in the enrollee’s medical record or identification number. Note that the enrollee’s HIC number ~~may~~ must not be used.

**{Insert type} – Insert the kind of service being terminated, i.e., skilled nursing, home health, or comprehensive outpatient rehabilitation services.**

**Bullet # 1** The facts used to make this decision: Fill\_in the patient\_specific information that describes the current functioning and progress of the enrollee with respect to the services being provided. Use full sentences, in plain English.

**Bullet # 2** **The detailed explanation of why your services are no longer covered under your plan:** Fill\_in the detailed and specific reasons why services are either no longer reasonable or necessary for the enrollee or are no longer covered according to the Medicare guidelines. Describe how the enrollee does not meet these guidelines.

**Bullet # 3** **The plan policy, provision, or rationale used in the decision:** Fill\_in the reasons services are either no longer reasonable or necessary for the enrollee or are no longer covered according to the plan's policy guidelines. Describe how the enrollee does **not meet these guidelines**. **If the plan relied exclusively on Medicare coverage guidelines,** please indicate so here.

**If you would like a copy of the policy:** **If the plan has not provided the Medicare guidelines or policy used to decide the termination date, inform the enrollee how and where to obtain the policy. The plan should provide a telephone number for enrollees to get a copy of the relevant documents sent to the QIO. If a provider has been delegated to supply this information, the provider's contact number should be included.**

**According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0910. The time required to complete this information collection is estimated to average 1.25 hours or 75 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**