2011 (old version)	2014 (new version)	Type of Change	Reason for Change
A Medicare provider or health plan must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services, no later than two days before the termination of services.	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	Rev	Improve precison and clarity of instructions.
This notice fulfills the requirement at 42 CFR 405.1200(b)(1) and (2) and 42 CFR 422.624(b)(1) and (2). In situations where the termination decision is not delegated to a provider by a health plan, the plan must provide the service termination date to the provider not later than two days before the termination of services for timely delivery to occur.	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.	Rev	Improve precison and clarity of instructions.
New language for 2014	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.	Rev	Improve precison and clarity of instructions.

Valid Notice Delivery	Provider Delivery of the NOMNC	Rev	Improve precison and clarity of instructions.

The notice must be validly delivered. Valid delivery means that the beneficiary/enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The beneficiary/enrollee must be able to understand that he or she may appeal the termination decision. If the beneficiary/enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative. Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if a beneficiary/enrollee is not able to physically sign the notice to indicate receipt, then delivery may be proven valid by other means. Valid delivery also requires delivery of an Office of Management and Budget (OMB) -approved notice consistent with either the standardized OMB-approved original notice format. In general, notices are valid when all patient specific information required by the notice is included, and any non-conformance is minor; that is, the non-conformance does not change the meaning of the notice or the ability to request an appeal. For example, misspelling the word "health" is a minor non-conformance of the notice that would not invalidate the notice. However, a transposed phone number on the notice would not be considered a minor non-conformance since the beneficiary/enrollee would not be able to contact the QIO to file an appeal. Errors brought to the attention of the provider or plan should also be reported to the appropriate regional office staff member.	Removed for 2014	Rev	Improve precison and clarity of instructions.

New language for 2014	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	Rev	Improve precison and clarity of instructions.
Notice Delivery to Incompetent Beneficaries/Enrollees in an Institutionalized Setting	Notice Delivery to Representatives	Rev	Improve precison and clarity of instructions.

Special Circumstances Do not use the NOMNC if coverage is being terminated for any of the following reasons: • Because the Medicare benefit is exhausted; • For denial of Medicare admission; • For denial of services that is not a Medicare benefit; or • Due to a reduction or termination of a Medicare service that does not end the skilled Medicare stay. In these cases, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage (NDMC). Special Circumstances Do not use the NOMNC if coverage is being terminated for any of the following reasons: • Because the Medicare benefit is exhausted; • For denial of Medicare admission; • For denial of services that is not a Medicare benefit; or • Due to a reduction or termination of a Medicare service that does not end the skilled Medicare stay. In these cases, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage (NDMC).	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).	Rev	Improve precison and clarity of instructions.

In these cases, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage (NDMC).	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.	Rev	Improve precison and clarity of instructions.
Modifications to the NOMNC The NOMNC is a standardized notice. Therefore, plans and providers may not re-write, re-interpret, or insert non-OMB-approved language into the body of the notice except where indicated. Without CMS regional office approval, however, you may modify the notice for mass printing to indicate the kind of service being terminated if only one type of service is provided by the facility; that is, skilled nursing, home health, or comprehensive outpatient rehabilitation facility. You may also modify the form to reference the kind of plan issuing the notice. Notices may not be highlighted or shaded. Additionally, text must be no less than 12-point type, and the background must be high contrast. Please note that the CMS form number and the OMB control number must be displayed on the notice. Substantive modifications, such as wrapping a letter format around the notice, may not be adopted without regional office approval. Regional office approval must be obtained for each modification not described in these instructions or other CMS guidance. Plans should contact their CMS regional office for additional questions regarding modifications to the notice.	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.	Rev	Improve precison and clarity of instructions.

Member number: Providers may fill in the enrollee's unique medical record or other identification number. Note that the enrollee's HIC number must not 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.	Rev	Improve precison and clarity of instructions.
Plan contact information:	Plan contact information (Plans only):	Rev	Improve precison and clarity of instructions.
Signature line: The enrollee or the representative must sign this line.	Signature line: The beneficiary/enrollee or the representative must sign this line.	Rev	Improve precison and clarity of instructions.
Date: The enrollee or the representative must fill in the date that he or she signs the document.	Date: The beneficiary/enrollee or the representative must fill in the date that he or she signs the document.	Rev	Improve precison and clarity of instructions.

Type of Change: Rev = Revision, Del = Deletion, Add = Addition, and Red = Redesgnation.

Burden Change
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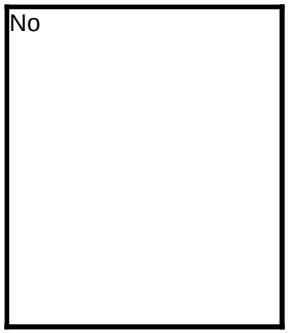
Type of Change: Rev = Revision, Del = Deletion, Add = Addition, and Red = Redesgnation.



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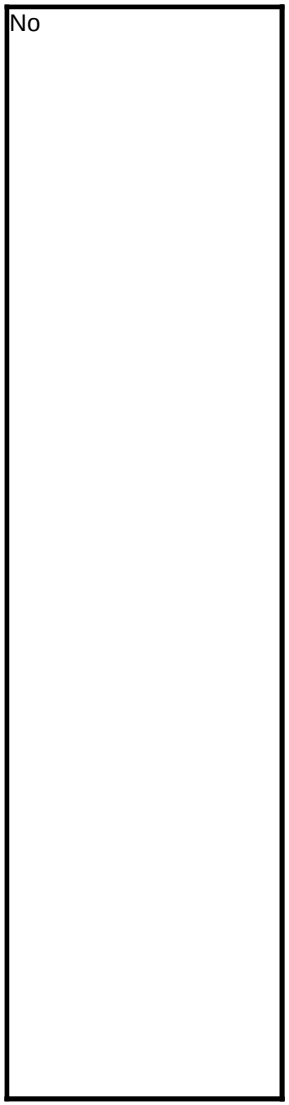

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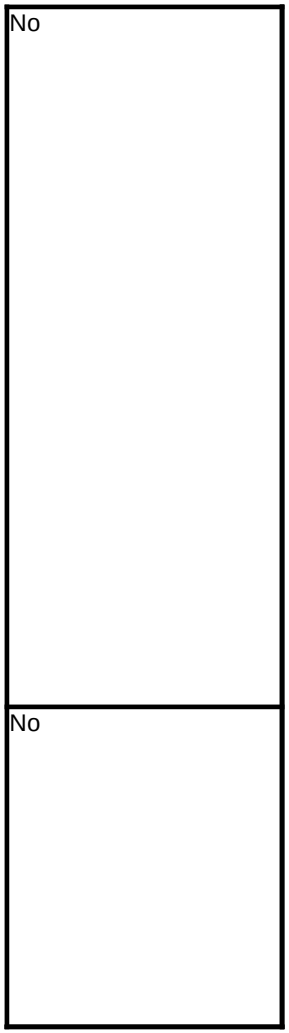

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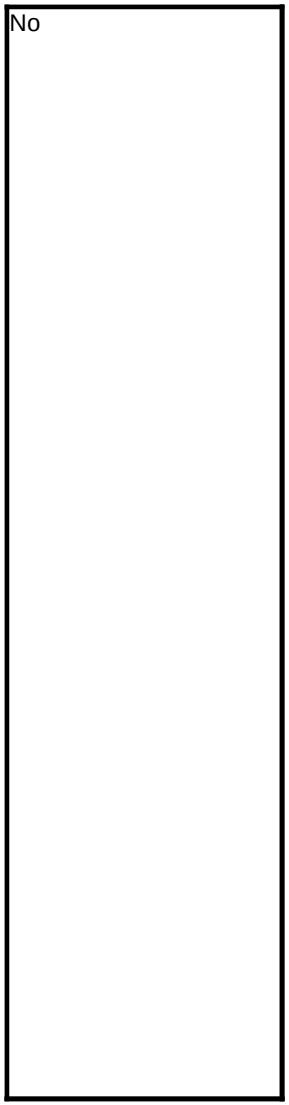

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