Notice of Medicare Non-Coverage
(NOMNC)
CMS-10095

When to Deliver the NOMNC

A Medicare Health provider must give an advance, completed copy of this notice, on behalf of an plan, to enrollees receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services, not later than two days before the termination of services This notice fulfills the requirement at 42 CFR 422.624(b)(2). In situations where the termination decision is not delegated to a provider, 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.

Valid Notice Delivery

Plans and providers will note that the notice must be validly delivered. Valid delivery means that the enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The enrollee must be able to understand that he or she may appeal the termination decision. If the 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 an 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 OMB approved notice consistent with either the standardized OMB-approved original notice format, or a regional office approved variation of the OMB approved format. Details regarding what constitutes an approved variation of an OMB approved format are included in these form instructions, in published FAQs and chapter 13 manual instructions.

In general, notices are valid when all patient specific information required by the notice is included, and any non-conformance is minor i.e., it 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 enrollee would not be able to contact the QIO and or health plan to file an appeal. Errors brought to the attention of the plan or provider should also be reported to the regional office plan manager. The plan manager may assist the plan in correcting the error, determine what corrective action may be required, and re-approve any subsequent variations of the NOMNC.

Notice Delivery to Incompetent Enrollees in an Institutionalized Setting

CMS requires that notification of changes in coverage for an institutionalized enrollee who is not competent be made to a representative acting on behalf of the enrollee. 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 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 notice of noncoverage 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.

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 non-Medicare covered services; or,
- due to a reduction or termination of a Medicare services that do not end the skilled Medicare stay.

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

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 Regional office approval, you may **modify the notice** for mass printing to indicate the kind of service being terminated if only one type of service is provided, i.e., 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 and disclosure statement 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 the instructions and notice FAQs. Plans should contact their regional CMS office for additional questions regarding modifications to the notice.

Heading

Logo: The name, address and telephone number of the plan or 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. If the plan's name and contact information is not in the space above the title of the form, it must be displayed elsewhere on the form for the enrollee's use in case an expedited appeal is requested, or the enrollee or QIO seeks the plan's identification.
THE EFFECTIVE DATE YOUR {INSERT TYPE} SERVICES WILL END: {Insert Effective Date}: Fill in the type of services ending, {**home health, skilled nursing, or comprehensive outpatient rehabilitation services**} 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 N/A

Bullet # 2 N/A
Bullet # 3 N/A

Bullet # 4 N/A
Bullet # 5 N/A

HOW TO ASK FOR AN IMMEDIATE APPEAL

Bullet # 1 N/A

Bullet # 2 N/A

Bullet # 3 N/A

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

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

Date: The 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.

Optional: Additional information. This section allows the MA plan and/ or provider to insert 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.

Member ID number: Plans and providers may fill in the enrollee's unique medical record or other identification number. Note that the enrollee's HIC number may not be used.