DETAILED EXPLANATION OF NON-COVERAGE (DENC) CMS-10095

A Medicare Health 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;
- for denial of non-Medicare covered services; or
- due to a reduction or termination of a Medicare 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. Please note that the OMB control number and disclosure statement must be displayed on 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 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. 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.

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

Patient Name: Fill in the enrollee's full name

Member ID number: Fill in the enrollee's Medical Record or ID number. Note that the enrollee's HIC number may 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 Indicate whether the type of review involves medical necessity, coverage limitations, or both.

Bullet # 2 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 # 3 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 coverage guidelines. Describe how the enrollee does not meet these guidelines.

Bullet # 4 The plan policy, provision, or rationale used in the decision: Fill in the reasons why 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 the Medicare coverage guidelines, indicate 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 of 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.