Form Instructions for the Detailed Explanation of Non-Coverage (DENC)
CMS-10124

A Medicare provider/health plan ("plan") must provide a completed copy of this notice to beneficiaries/enrollees receiving skilled nursing, home health, comprehensive outpatient rehabilitation facility , and hospice services upon notice from the Quality Improvement Organization (QIO) that the beneficiary/enrollee has appealed the termination of services in these settings. This notice fulfills the requirements at 42 CFR 405.1202(f)(1) and 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 Medicare home health services;
- For denial of a service that is not a Medicare benefit; or
- Due to a reduction or termination of a Medicare-covered service that does not conclude the skilled Medicare stay.

Health Plans only: in these cases, the plan must issue the CMS form 10003 – Notice of Denial of Medical Coverage (NDMC).

The DENC is a standardized notice. Providers/plans may not deviate from the wording or content of the form except where authorized to do so. Notice entries may be typed or handwritten. Handwritten entries must be at least as large as 12-point type and legible.

Heading

Insert contact information here: The name, address and toll-free number of the provider or plan 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 provider or plan.

Patient Name: Fill in the beneficiary/enrollee first and last name.

Member number: Fill in the beneficiary/enrollee medical record or identification number. Note that the HIC number must not be used.

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

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

Bullet # 2 The detailed explanation of why the services are no longer covered. Fill in the detailed and specific reasons why services are either no longer reasonable or necessary for the beneficiary/enrollee or are no longer covered according to the Medicare guidelines. Describe how the beneficiary/enrollee does not meet any applicable guidelines. Providers/plans may add an additional page or provide additional information on the back of the DENC if more space is needed. If adding information that will not fit in this space, please include in bold letters "**please see attached page for more information**" or "**please turn the page over for more information**" at the bottom of this section.

Bullet # 3 **Health Plans only:** The plan policy, provision, or rationale used in the decision if the notice is delivered to a health plan enrollee: 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: Tell the beneficiary/enrollee how and where to obtain a copy of the policy. The provider/plan should provide a toll-free number for beneficiaries/enrollees to get a copy of the documents that were sent to the QIO.