Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Post-acute care: NOMNC and DENC forms

Guidance and instructions

For Medicare Plus Blue℠ and BCN Advantage℠

October 2024

In this document

This document contains information about completing the following forms for skilled nursing facilities, or SNFs:

- *Notice of Medicare Non-Coverage*, or *NOMNC*
- *Detailed Explanation of Non-Coverage*, or *DENC*

The NOMNC form

Centers for Medicare & Medicaid Services requires that the *NOMNC* be delivered to members at least two days before the last covered service date. The *NOMNC* can be issued earlier to accommodate a weekend or to provide a longer transition period. Deliver the *NOMNC* as early in the week as possible to minimize the possibility of extended liability for weekend services.

The process to deliver the *NOMNC* varies depending on who makes the decision to end care:

Decision made by	Process
Blue Cross Blue Shield of Michigan or Blue Care Network	Blue Cross or BCN will complete the *NOMNC* and provide it to the skilled nursing facility to deliver to the member.
The health care provider	The healthcare provider must complete the *NOMNC* and deliver it to the member.

Per CMS 100-04 Chapter 30 section 260.3.6:*

- If the facility or health care provider fails to deliver the *NOMNC* to the member, the provider may be held financially liable for continued services until two days after the member receives a valid notice or until the effective date of the valid notice, whichever is later.

- Providers may not balance bill members for these services.

Preparing to complete the NOMNC

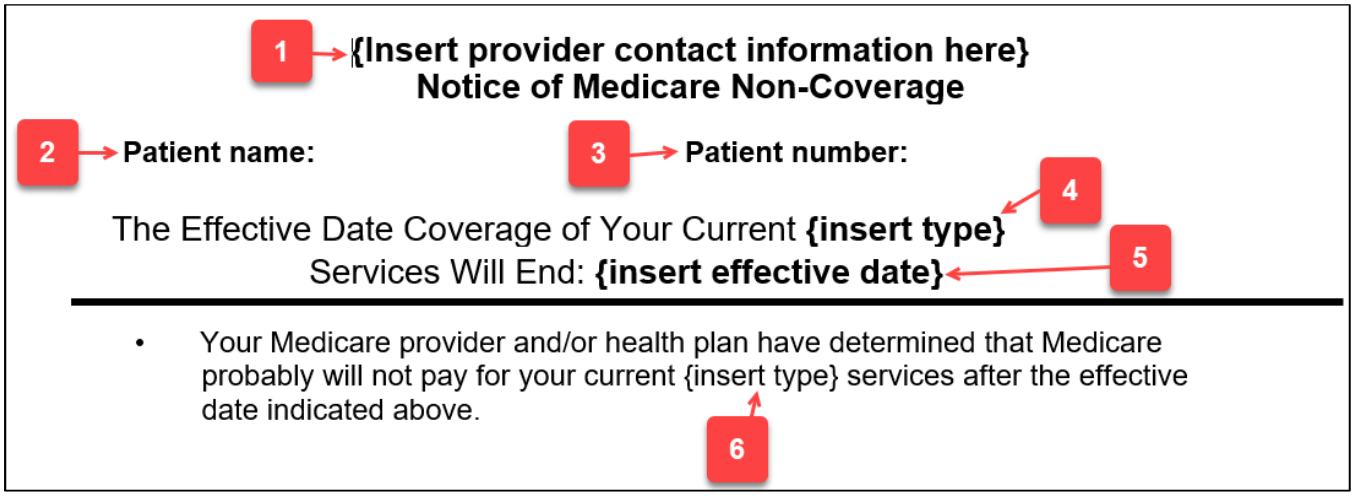
When preparing to end services:

1. Identify the last day of covered service and discuss it with the patient, family or authorized representative.
2. Download the *NOMNC* from the FFS & MA NOMNC/DENC page on **cms.gov**.*

Complete the NOMNC

This information includes detailed information about how to complete the Microsoft Word document for the *NOMNC*.

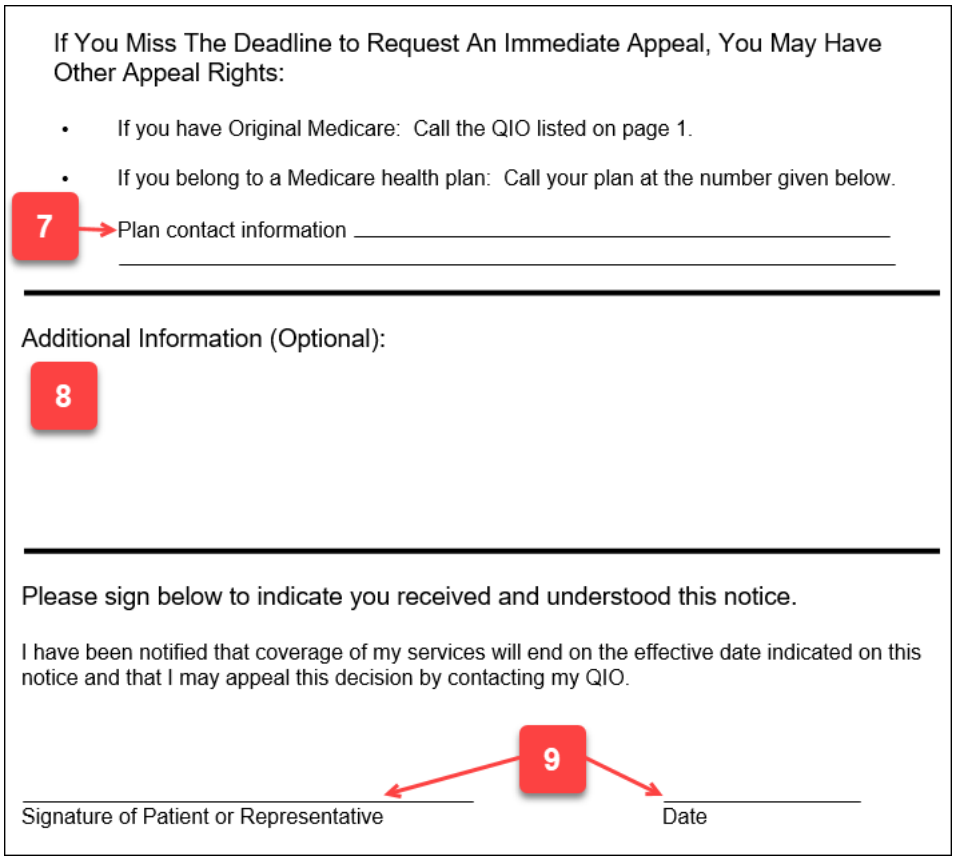
Fill out the top of page 1 as shown below.



1. Enter the delivering provider's name, address, and telephone number above the title of the form.
2. Enter member's name.
3. Enter the member's Blue Cross or BCN subscriber ID.

   Note: If the subscriber ID isn't available, enter the facility medical record number. Don't enter the patient's Medicare number.
4. Enter the type of service to be terminated (skilled nursing service days or home health visits).
5. Enter the last day the service is covered.
6. Enter the type of service.

Fill out page 2 as shown below.



7. Enter the contact information for Blue Cross or BCN.
8. Document the following information in this section, based on the situation:

Situation	What to document
Form is completed **in person by the member**	a. The name of the staff person who initiated contact with the member b. The date on which services will end c. Include a note that the following were given to the member: ○ The full appeal rights ○ The contact information (including phone numbers) for the Quality Improvement Organization, or QIO, and for Blue Cross or BCN d. The date and time by which the member must contact the QIO to request an immediate (fast) appeal.

Situation	What to document
Form is completed **in person by the member's representative**	If the member is unable to comprehend or sign the form, the member's authorized representative can sign it. Include: a. The name of the staff person who initiated contact with the member's representative b. The name of the member's authorized representative c. The date on which services will end d. Include a note that the following were given to the member: ○ The full appeal rights ○ The contact information (including phone numbers) for the QIO and for Blue Cross or BCN e. The date and time by which the member's representative must contact the QIO to request an immediate (fast) appeal.
Form is completed **over the phone** by the member's representative	If the member is unable to comprehend or sign the form, an authorized representative can sign it. If the authorized representative can't sign the *NOMNC* in person, you can work with them to complete it over the phone. The form **must** include the following items to be considered valid: a. The name of the staff person initiating contact with the member's representative b. The name of the member's authorized representative c. The date on which services will end d. The following details about the phone call: ○ The date and time of the phone call — This is the same date on which the member's authorized representative is given notice ○ The phone number you called e. Include a note that the following were given to the member's representative: ○ The full appeal rights ○ The contact information (including phone numbers) for the QIO and for Blue Cross or BCN f. The date and time by which the member or member's representative must contact the QIO to request an immediate (fast) appeal.

Note: The QIO is the independent reviewer authorized by Medicare to review the Blue Cross or BCN decision to end SNF services.

9. The member or the member's representative must sign and date the form. The date must be two days before the last covered day.

   Important: If the member or their representative refuses to sign the form, include a note that the form was delivered; be sure to include the date.

What to do with the completed NOMNC form

On the day on which the *NOMNC* is completed, do the following:

1. Provide the completed form to the member or the member's representative as follows:
    - If it was completed in person, give a copy of the form to the member or to the authorized representative who signed it.
    - If it was completed by phone, mail the completed form to the member's authorized representative on the day it's completed.
2. Place a copy of the form in the patient's medical record.
3. Send the form to Blue Cross or BCN using one of the following methods:
    - **Preferred method:** Attach the form to the Case Communication field in the e-referral system.
    - **Nonpreferred method:** Fax the form to 1-866-796-3713.

What else to do before discharging the member

Before discharging the patient, include the following in the member's medical record:

- A description of the discharge plan
- A physician note that reflects the member's readiness for discharge
- Therapy notes that reflect discharge status and rationale — Include brief notes indicating that member will be coming off of or reducing skilled services and that the plan of care has been completed. You don't need to include a full discharge summary.

In addition, discuss the discharge plan with the member or the member's caregivers.

What's required if the member chooses to discharge before the designated day

The member may choose to discharge sooner than the designated day. When this happens:

- The *NOMNC* must still be signed
- A note should be added to the Additional information (Optional) section detailing the circumstances of the early discharge.

What happens if a member appeals the decision to end care

If the member chooses to appeal, they must request a review by the Quality Improvement Organization, or QIO, listed on the *NOMNC* no later than noon the day before services are scheduled to end. The QIO appeal decision is typically issued within 48 hours of the member's request for review.

When the *NOMNC* is issued two days before the last covered day, the servicing provider must provide the member's medical record to the QIO listed on the *NOMNC* as follows, based on when the member files the appeal:

The member files the appeal…		You must submit the medical record to the QIO by…
The day the *NOMNC* is issued	Before noon	5 p.m. the same day
	After noon	Noon the next day
The day **after** the *NOMNC* is issued	Before noon	5 p.m. the same day

The DENC form

When a member initiates an expedited review based after receiving the *NOMNC*, the *Detailed Explanation of Non-Coverage*, or *DENC*, form is delivered to the member by the close of business on the same day that the QIO is notified of the member's request for appeal.

The process to deliver the *DENC* varies depending on who makes the decision to end care:

Decision made by	Process
Blue Cross Blue Shield of Michigan or Blue Care Network	Blue Cross or BCN will complete the *DENC* and send it to the skilled nursing facility. The SNF must then deliver the *DENC* to the member.
The health care provider	If Blue Cross or BCN receives a QIO request, Blue Cross or BCN will notify the provider. The provider must provide the following to Blue Cross or BCN: • The completed *DENC* • Supporting clinical documentation for the discharge The provider should attached the above items to the Case Communication field in the e-referral system.

Per CMS 100-04 Chapter 30 section 260.3.6:*

- If the facility or health care provider fails to deliver the *DENC* to the member, the provider may be held financially liable for continued services until two days after the member receives a valid notice or until the effective date of the valid notice, whichever is later.
- Providers may not balance bill members for these services.

Complete the DENC

The DENC must be completed and submitted by the entity that determines that covered services are ending (Blue Cross, BCN or the SNF provider). Blue Cross or BCN may request medical records or other pertinent clinical information from the provider to assist with the completion of this step within the short time frames mandated by CMS regulations.

The DENC must include specific and detailed information about why the member's SNF services are ending, including:

- The information used to make the decision that services should end
- A detailed explanation of why the services will no longer be covered along with the specific Medicare coverage rules and policy used to make the decision
- When issued by the health plan, it includes the plan policy, provision or rationale used in making the decision.

For detailed instructions on how to complete the *DENC*, go to the FFS & MA NOMNC/DENC page on **cms.gov**.*

How a member can request a copy of the criteria used to make the decision to end services

If a member would like a copy of the policy or coverage guidelines used to make the decision or if they want Blue Cross or BCN to send a copy of the documents the QIO, call Blue Cross of BCN as follows:

- For Medicare Plus Blue members, call 1-866-309-1719.
- For BCN Advantage members, call 1-800-249-5103.

TTY users should call 711.

Additional information

For additional information, see our provider manuals:

- Medicare Plus Blue PPO Provider Manual
- BCN Advantage chapter of the BCN Provider Manual

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