

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

A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as “plans”) must deliver a completed copy of this notice to beneficiaries/enrollees receiving covered 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. The DENC 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).

Alterations to the DENC

Providers may include their business logo and contact information on the top of the DENC. Text may not be moved to a second page to accommodate large logos, address headers, etc.

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. The beneficiary/enrollee 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 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 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 explain that 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 beneficiary/enrollee how and where to obtain the policy. Provide a telephone number for beneficiaries/enrollees to get a copy of the relevant documents that were sent to the QIO.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0953**. The time required to complete this information collection is estimated to average **1.25 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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OMB Approval No. 0938-0953