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How To Complete and Give the Notice of Medicare Non-Coverage

Acentra Health is the Beneficiary and Family Centered Care Quality Improvement Organization (also referred to as a BFCC-QIO) for the [29 states](#) shown on the organization's home page. One of the responsibilities of the BFCC-QIO is to help healthcare providers understand rules set forth by the Centers for Medicare & Medicaid Services (CMS).

Home health agencies, skilled nursing facilities (SNF), hospices, and comprehensive outpatient rehabilitation facilities (CORF) are required to provide a Notice of Medicare Non-Coverage (also referred to as a **NOMNC**) to patients when their Medicare-covered service(s) is ending.

The NOMNC tells patients how to request an expedited determination from their BFCC-QIO.

USING THE RIGHT FORM

Providers must use the CMS-approved Notice of Medicare Non-Coverage (NOMNC).

You must fill in:

- Patient's name
- Patient number [Note: don't use the Social Security Number, HICN, or MBI].
- Type of coverage (SNF, Home Health, CORF, or Hospice)
- Effective date (last day of coverage)

WHAT CAN BE CHANGED ON THE FORM:

Unapproved changes may invalidate the NOMNC. Only a few changes are allowed:

- The NOMNC must remain two pages. The notice can be two sides of one page or one side of two separate pages. It must not be condensed to one page.
- Providers may include their business logo and contact information at the top of the NOMNC. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, etc.
- Providers may include information in the optional "Additional Information" section relevant to the patient's situation. Providers may also document telephone notification in the "Additional Information" section.

WHEN TO GIVE THE NOMNC

Providers must deliver the NOMNC to all patients eligible for the expedited determination process. It must be delivered even if the patient agrees with the termination of services.

The provider must make sure the patient (or their representative) signs and dates the notice to show they received it and understand they can disagree with the decision to end care. The beneficiary is able to ask the representative to sign on his/her behalf.

TIME FRAME

The NOMNC must be given to the patient at least two calendar days before their Medicare-covered services end. If care is not provided every day, the notice must be given no later than the second-to-last day care is provided. For example, if the last day of the covered SNF care is a Friday, the NOMNC should be delivered no later than the preceding Wednesday.

The two-day rule is based on calendar days, not 48 hours. For example, if a patient's last covered home health service is at 10 AM on Wednesday and the notice is delivered at 4 PM on the prior Monday, it is considered timely.

The NOMNC can be delivered earlier than two days before services end, but it should be close enough to the discharge date so that the patient understands and remembers their right to request a fast (expedited) review.

The notice should not be given at the start of care unless the services are expected to last fewer than two days. In that case, the provider may give the notice at the beginning.

For Home Health Agencies:

- If home health services are being provided less frequently than daily, the notice must be delivered no later than the next to last visit before Medicare-covered services end. For example, if home health care is provided on Tuesdays and Thursdays, and Tuesday is the last day of Medicare-covered services, the notice must be delivered no later than the preceding Thursday.
- If a patient is receiving home health care and is found to no longer be homebound, they are no longer eligible for Medicare-covered home health services. In this case, the NOMNC must be delivered immediately when the loss of homebound status is identified.

MORE INFORMATION

Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-nomnc-denc

You'll find:

- Current versions of the Notice of Medicare Non-Coverage (NOMNC) form.
- Full instructions for the Original Medicare, also known as Fee for Service (FFS), expedited determination process are available in Section 260, of Chapter 30 of the CMS Claims Processing Manual.
- Full instructions for the Medicare health plan expedited determination process, also known as the Medicare Advantage (MA) fast track appeals process, are available in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, in Section 100.
- Find news and updates regarding appeals on Acentra Health's website: www.acentraqio.com/providers/appeals.
- You can also subscribe to Acentra Health's newsletter, Case Review Connections, to receive important updates as well as news and information from the Centers for Medicare & Medicaid Services (CMS): www.acentraqio.com/newsletter/crc