

Crosswalk Document for Changes to CMS-10003-NDMCP
Notice of Denial of Medical Coverage (or Notice of Denial of Payment)
Submitted for 30 day comment period March 2013

Summary of Changes to Notice:

The following changes have been made to the notice as a result of comments received during the 60 day notice and comment period or for the purpose of enhancing the clarity or accuracy of the notice:

- We've added an "Important" note at the top of the notice that briefly explains the purpose and contents of the notice and refers readers to the "Get help & more information" section on the back page.
- We've added bracketed text to the header field indicating that additional identifying information can be included to accommodate additional fields required to identify a full dual eligible enrollee (e.g., Medicaid number).
- We've included the term "denied" as an option in the brackets in the sections entitled "Your request was denied" and "Why did we deny your request?" as opposed to having it as the default option since a Medicare Advantage plan may also issue the notice for a reduction or discontinuation of a previously authorized course of treatment. We also changed the bracketed term "terminated" to "stopped" for plain language purposes and added a brief instruction to plans to "Insert appropriate term".
- In the section entitled "Why did we deny your request?" we added clarifying text (that comports with the notice instructions) that the health plan must provide a specific rationale for its decision in the free text field, in addition to including the relevant citation to law/regulation or plan documents to support the decision.
- In the section entitled "You have the right to appeal our decision" we've added text explaining that if the enrollee asks for a plan appeal first, s/he may miss the deadline for requesting a State Fair Hearing. This is language that would only be included, as applicable, for a full dual eligible enrollee. Also in this section, we deleted "you must" before "ask" so that the notice simply states "Appeal: ask...for an appeal"
- Before the title "There are 2 kinds of appeals" we've added a notation "Important Information About Your Appeal Rights." This notation is on the currently approved form and we received a comment that it should be retained.
- In the sections "Standard Appeal" and "Fast Appeal" we changed "We must give you a written decision" to "We'll give you a written decision" for brevity/clarity.
- In the section "How to ask for an appeal" we've added a bracket indicating that the plan must insert the health plan name.
- Under "Step 2" we changed "should" to "must" before the list of information that constitutes a valid appeal request so it's clear that this is the minimum amount of information necessary for the plan to adjudicate the request and provide the enrollee with a decision. In the bracketed text under "Step 1" we deleted "anytime" because it doesn't add anything; for clarity, it will now state "You can ask to see the medical records...we used to make our decision before or during the appeal."

- Under “Step 2” we clarified that, in addition to mailing or faxing the standard appeal request (or making a verbal request if the plan accepts standard appeal requests verbally), the request can be delivered to the plan. We deleted the text “in person” because it is misleading and may incorrectly suggest that an in person hearing will be held. In the bracketed text under “Step 2” we deleted the text that the enrollee will be asked to sign the letter confirming the verbal standard appeal request. This requirement has been eliminated per revised Chapter 13 of the Medicare Managed Care Manual. The plan must send the letter confirming the verbal request, but the enrollee no longer needs to sign and return the letter.
- In the section “What happens next?” we added text indicating that the plan will “send you a written decision” for additional clarity on what the enrollee can expect if the plan upholds the denial.
- In the “How to ask for a Medicaid State Fair Hearing” section (language that will be included only in the case of a full dual eligible enrollee where the plan has denied a Medicaid service), we have added specific instructions for the information that must be included with a request for a State Fair Hearing.
- In the section entitled “What happens next?” we’ve added a bracket indicating that the plan should note who a copy of the notice has been sent to. Per a comment received, Medicaid may require that a copy of the notice be furnished to another individual or entity, such as the enrollee’s provider or the Ombudsman.
- In the “Get help & more information” section, we’ve added a field for the plan’s hours of operations and a notation that 1-800-Medicare can be contacted 24 hours per day/7 days per week. We’ve also added a bracket indicating that the plan must insert Medicaid/State contact information, if applicable.

Summary of Changes to Instructions:

The following changes have been made to the instructions as a result of comments received during the 60 day notice and comment period or for the purpose of enhancing the clarity or accuracy of the instructions:

- Text has been added to the introductory paragraph to provide additional explanation that text shown in square brackets is to be inserted if the enrollee is a full dual eligible and the denied service/item is subject to Medicaid appeal rights. For further clarity on that point, the term “optional” has been deleted from the explanation of the insertion of the Medicaid language in the third sentence.
- In the “Heading” section, changed “Enter” to “Insert” for consistency and added an instruction that a plan is permitted to insert additional fields of information in the header section of the notice consistent with applicable State requirements (e.g., enrollee’s Medicaid number).
- In the “Your request was denied” section, additional explanation has been added that the plan must insert the appropriate bracketed term to describe the action taken; that is, whether the service was denied, stopped, reduced or, in the case of a Medicaid service,

suspended. We added an explanation that “suspended” means temporary stoppage of service. Further instruction was added that the plan must clearly and specifically list the denied services/items.

- In the “Why did we deny your request” section, additional explanation has been added that the plan must insert the appropriate bracketed term to describe the action taken; that is, whether the service was denied, stopped, reduced or, in the case of a Medicaid service, suspended. We added an explanation that “suspended” means temporary stoppage of service.
- In the “You have the right to appeal our decision” section, instruction has been added that the plan must insert the plan name and, in the case of a Medicaid service, must insert applicable timeframes for requesting a State Fair Hearing.
- In the section entitled “How to ask for an appeal” we’ve added an instruction that the plan’s name must be inserted in the section title (as shown by the bracketed text in the notice) and have provided clarifying instruction that if the plan accepts standard appeal request by phone, the plan must insert the relevant bracketed text. Other minor wording changes were made to this section for clarity.
- In the section entitled “How to ask for a Medicaid State Fair Hearing/What happens next?” we added clarifying instructions to the notice that the optional Medicaid text shown in brackets on the notice must be included if the plan manages both Medicare and Medicaid benefits and the service/item is subject to Medicaid appeal rights.
- In the section entitled “Get help & more information” we added clarifying instructions that if the notice involves a Medicaid service, the plan must insert Medicaid/State contact information.