

Comments Received on Integrated Denial Notice (CMS–10003) – 60 day comment period

Document (specify notice, instructions, burden estimates)	Page # (if applicable)	Comment (commenter and summary of comment)	CMS Response
Notice	All	<p>Gail Coleman Commonwealth Care</p> <p>1. Commenter notes that Medicare and Medicaid appeal time frames are different and believes it is unclear what day limits CMS wants plans to use because the two processes are not yet integrated.</p> <p>2. Commenter suggests several specific changes to the notice, including changes to optional terms included in various brackets and wording changes to make it clearer that certain sections apply to requesting an appeal from the plan (as opposed to a State Fair Hearing). Specifically, commenter believes:</p> <ul style="list-style-type: none"> - “Denied” should be in brackets - “Doctor” should be placed in brackets - Keep the “Appeal” section for Medicare appeals exclusively and State Fair Hearing section for Medicaid appeals - Retain header on p. 2 (“Important Information About Your Appeal Rights”) - On p. 2 make it clearer which sections relate to the plan appeal - On p. 3 add, make it clear what the enrollee should 	<p>1. CMS acknowledges that the timeframes for requesting Medicare and Medicaid appeals differ, but expects health plans to work with the State Medicaid agency to insert the appropriate Medicaid time limits for requesting an appeal, as applicable. Under the “You have the right to appeal our decision” section, 2nd paragraph, plans have the option to insert a State Medicaid timeframe for requesting an appeal if the service that was denied (and subject to an appeal request) is a Medicaid service. Accordingly, we did not accept the commenter’s suggestion to remove the bracketed option for inserting the State Medicaid timeframe (if different from Medicare) for plan level appeals. As noted above, we believe the plan should have the flexibility to insert the Medicaid timeframe for requesting an appeal, as appropriate.</p> <p>2. Per commenter’s suggestion, we have included “denied” as an option in the curly brackets in the sections “Your request was denied” and “Why did we deny your request?” (as opposed to having it as the default option) since, under Medicare Advantage rules, the notice may also be used for a reduction or discontinuation of a previously authorized course of treatment. We also changed “terminated” to “stopped” for purposes of plain language/clarity.</p> <p>We did not accept the suggestion to add the term “doctor” to the brackets</p>

		<p>include with a SFH request</p> <ul style="list-style-type: none"> - Revise the “Get help” section to make it clearer that the enrollee can contact the plan, add plan hours of operation and indicate that 1-800-Medicare can be reached 24/7. 	<p>with “provider” and have retained “doctor” as the default option. Under Medicare Advantage regulations, only a physician is permitted to request an appeal on an enrollee’s behalf; this does not apply to other providers so we believe it would be misleading to suggest that another type of provider could request the appeal on the enrollee’s behalf without being the enrollee’s appointed representative. We have retained “provider” in hard brackets as a Medicaid option.</p> <p>Per commenter’s suggestion, we have added specific instructions for the information that should be included with a request for a State Fair Hearing (name, address, member #, reasons for appealing, evidence to include with request).</p> <p>We also accepted the comment to add 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.</p> <p>We also accepted other suggestions made by the commenter, including adding text to make it clearer which sections apply strictly to requesting a plan appeal and retaining the header on page 2 (on currently approved CMS-10003) that states the notice contains important information about appeals rights.</p>
Notice	All	<p>David Certner Legislative Counsel and Legislative Policy Director AARP</p> <p>1. Without clear language on the form and clear instructions to Medicare health plans, the new form could increase</p>	<p>1. CMS believes that the notice and instructions provide clear guidance to health plans. The notice combines the Notice of Denial of Medical Coverage and the Notice of Denial of Payment which are currently in use. Further, CMS has offered health plans optional language that can be used to</p>

		<p>confusion for beneficiaries who are eligible for Medicare and full Medicaid under a state Medicaid plan.</p> <p>2. While AARP lauds CMS' goal of creating an integrated form, it believes that the form does not clearly explain the differences between Medicare and Medicaid</p> <p>3. The difference between an appeal and a state fair hearing is not explained fully</p> <p>4. The form should contain an upfront explanation of how to understand the form itself and what information is being presented.</p> <p>5. If the beneficiary is dually eligible, the form should explicitly state that there is a difference between Medicare and Medicaid appeals procedures. In addition, the form should state which process is being used to adjudicate the denial decision.</p> <p>6. If the beneficiary is denied Medicaid benefits and is entitled to a State Fair Hearing, the form should clearly describe the differences between the health plan's appeal process and a State Fair Hearing. It should also explain why a beneficiary may want to file a health plan appeal and a State Fair Hearing concurrently (if applicable).</p>	<p>customize the letter to make communication as clear as possible to beneficiaries if a Medicaid service is denied.</p> <p>2. CMS agrees that integrating the notices will promote better access to the appeals process for beneficiaries. The form will communicate denial of services and payments in one document, making it easier for beneficiaries to understand and will also, as appropriate, include information on Medicaid appeal rights.</p> <p>3. The form requires an explanation of the appeals and state hearing processes. Given variances in Medicaid appeals processes, plans will be responsible for populating certain information in free text fields.</p> <p>We believe the level of detail the commenter is proposing is more appropriately set forth in the plan's Evidence of Coverage (EOC). This is a notice that seeks to highlight the key aspects of the appeal processes so the enrollee is made of aware of next steps to take to dispute the plan's decision. It is not intended to replace the more thorough explanation provided in the EOC.</p> <p>4. We have added some additional instructional information to the notice in an effort to enhance clarity. For example, we've added a statement to the top of the notice explaining that the notice contains important information about the enrollee's right to appeal and directs enrollees to the contact section on the last page if the enrollee needs assistance. Further, we believe the sections such as "We denied your request" and "Why did we deny your request?" make the form fairly straightforward and easy to understand. Again, the notice is not</p>
--	--	--	---

			<p>intended as a substitute for the Evidence of Coverage.</p> <p>5. We believe the free text fields are an appropriate place for health plans to explain why coverage has been denied and that the notice distinguishes between the two processes. Given that each State has its own Medicaid appeals rules, not all of the language that will need to be included in the notice can be standardized.</p> <p>6. Health plans have the flexibility through the optional language, “[Insert, if applicable: <i>and/or you can request a State Fair Hearing. You can ask for both types of review at the same time, as long as you meet the deadlines</i>]” to explain why it is better to pursue both processes simultaneously. Per comments we received, we have added text to attempt to more clearly distinguish plan appeals from SFHs. The notice is not meant to replace the more expansive appeals information provided in the plan’s Evidence of Coverage or effective advocacy for appropriate services.</p>
Notice	All	<p>Ann Berg Deputy Medicaid Director Minnesota Department of Human Services</p> <p>1. The form should allow for additional identifying fields in the member identification section to allow health plans under contract with State Medicaid agencies to assist the member in identifying the service being denied such as the member’s Medicaid or PMI number, provider of the service being denied,</p>	<p>1. We have modified the notice to accommodate additional fields to insert Medicaid related information, such as a member identification number, the provider whose service is being denied, authorization request, date of action and first date of service, as applicable.</p> <p>2. We have modified the notice to include a field for adding state Medicaid contacts.</p> <p>3. We have modified the notice to include a field to insert the names of</p>

		<p>authorization request, date of action and first date of service (as applicable).</p> <p>2. The form should provide space for Medicaid contacts in the get help and more information section such as a state ombudsman for managed health care.</p> <p>3. The form should require a notification section specifying who else received a copy of the letter if required by the state Medicaid agency. For example, Minnesota requires that the provider and ombudsman also receive a copy of the notices of denial.</p> <p>4. The use of the word “optional” also makes it unclear whether Medicare health plans must use an integrated Form CMS-10003 in all cases where a Medicare health plan enrollee also receives full Medicaid benefits that are being managed by the Medicare health plan. If CMS intends to require this form to be used in all such cases, CMS should work with State Medicaid agencies in advance of requiring the form to allow successful implementation and protection of beneficiaries.</p>	<p>persons or State agencies who also received a copy of the form.</p> <p>4. Use of CMS-10003 is mandatory under the Medicare Advantage (Part C) program. In addition, CMS expects health plans that manage benefits for enrollees who are eligible for both Medicare and Medicaid to use the notice in cases where a Medicaid service has been denied, which is why the optional Medicaid language has been included. CMS will work with State Medicaid agencies to ensure successful implementation of the new integrated form.</p>
Notice		<p>PA 15222 (unidentified commenter)</p> <p>Commenter requests sufficient notification be given prior to the compliance effective date in order to allow plans time to update systems, test, and implement use of the form.</p>	<p>When determining the date plans must begin using the integrated denial notice (following OMB approval), we will consider plans’ need to update and test systems in order to implement use of the notice.</p>

Notice		<p>Kim Piper Group Health Cooperative</p> <p>Commenter is concerned that use of this integrated denial notice will be burdensome for plans who use the EOB for payment denials and would require massive systems changes that would be onerous to implement. Requesting 2 years for implementation.</p>	<p>While commenter does not provide specifics on the types of system changes that would constitute “massive” changes, we recognize that plans using the EOB for payment denials will have to reprogram systems to include the newly approved standardized text of CMS-10003 (for use in Medicare payment denials). We will take this into consideration when determining an implementation deadline following OMB approval.</p>
Notice	p. 1	<p>Thomas Campbell Gateway Health Plan</p> <p>1. Commenter asks that the word “suspended” be defined, as used in this notice.</p> <p>2. Commenter asks that we confirm that one of the terms in the brackets is intended to replace the word “denied”.</p>	<p>1. CMS defines “suspended” as a temporary stoppage of a service. We will include this clarification in the instructions.</p> <p>2. We have modified these sections of the notice such that “denied” is included as an optional term within the brackets. The instructions are clear that the plan should select the appropriate term shown in the brackets (e.g., “denied,” “reduced”). For further clarity, we’ve added a brief instruction within the brackets to “insert appropriate term.”</p>
Notice and burden estimates		<p>Tribal Technical Advisory Group Alaska Native Tribal Health Consortium National Indian Health Board</p> <p>These 3 organizations submitted the same comments, most of which were outside the scope of this effort. For example, these organizations “encourage the</p>	<p>The comment related to the exchanges is outside the scope of this PRA package. The purpose of revising this existing package is to make necessary changes to the denial notice. It doesn’t affect underlying coverage and payment policies and will not apply to the Exchanges. It’s not clear which</p>

		<p>Secretary to draw upon the guidance issued under this regulation in fashioning the denial and appeal policies for the Exchanges.” Other statements appear to relate to FFS appeals, but this notice only applies in the managed care setting.</p> <p>Commenters also observed that the burden does not include an estimated burden for patients and their providers to respond.</p>	<p>“regulation” the commenter was referring to (again, this is a PRA package, not a rulemaking). The commenter also makes statements that appear to relate to FFS appeals, but this form is used in the managed care context exclusively. Commenter also seeks clarification on whether this notice applies in the Part D context, which it does not; the applicability of this notice is set forth in the supporting statement.</p> <p>The commenter is correct that the burden estimates do not account for a patient or provider “responding” to the notice. This would be outside the necessary burden estimates for this package; the burden estimate in this package properly accounts for the time/cost for a health plan to complete the notice when services are denied, reduced or stopped.</p>
--	--	--	---