Crosswalk Document for Changes to CMS-10003-NDMCP
Notice of Denial of Medical Coverage (or *Notice of Denial of Payment*)

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:

- Language has been added under the section "Why did we deny your request?" to notify members they can share a copy of the decision letter with their doctor to discuss next steps in their treatment plan.
- We have added language in the "Plan Appeal" sub-heading of "You have the right to appeal our decision" to reference what section within the notice members can find instructions on how to file an appeal.
- In the sub-heading entitled "State Fair Hearing" under the heading "You have the right to appeal our decision", we have removed the instruction for plans to insert the page number and placed a sectional reference due to the potential burden on plans to make changes to internal automated process systems.
- We've added language under the "You have the right to appeal our decision" section that refers readers to the appropriate section for instructions on how to ask for a State Fair Hearing.
- Under the heading "There are 2 kinds of appeals with {Health plan name}, the "Fast Appeal" section has been changed to indicate that this section may be deleted if the request being denied is for payment of an item or service that the enrollee has already received. This section is now in curly brackets and italicized to reflect this portion of the notice contains text to be inserted, as explained in the instructions.
- Bullet 5 in Step 1 under the heading "How to ask for an appeal with {health plan name}" may be deleted if the request is for payment of an item or service the enrollee has already received.
- We have changed text in "Step 2" under the heading "How to ask for an appeal with {health plan name}, from "Address" to "Mailing Address" and added "In-person delivery address" in curly brackets for plans to use, if applicable.
- Under sub-heading, "Step 2", we have inserted sections for plans to include a number for TTY users under the standard or fast appeal sections within curly brackets, if applicable.
- In Step 2 under the heading "How to ask for an appeal with {health plan name}, the "For a fast appeal" instruction is now in curly brackets and italicized to reflect this portion of the notice contains text that may be deleted, as explained in the instructions.

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 notice:

- On page 1 of the instructions that references the Spanish-language version of the notice, we removed the text “If this is impossible” so the instructions are clearer regarding the responsibility of the plan to provide a notice that is understandable to the enrollee.
- Additional language has been added in “Section Titled: Why did we deny your request?” to clarify what plans must include in the denial rationale.
- On page 1 of the instructions in the section “Section Titled: Why did we deny your request”, instructions have been added that state:
  -plans must determine if services are covered under the plan’s Medicare and/or Medicaid benefit;
  -the criteria plans are to take into consideration when making that determination; and
  -clarification on the circumstances under which the notice should be issued.
- Under “Fast Appeal”, we have added instruction that plans may delete this section of the notice if the denial notice is for a request for payment of an item or service that the enrollee has already received.
- Under “Step 2”, we have added instruction that plans may delete the “Fast Appeal” portion for notice of payment denials.