Form Instructions for the Notice of Denial of Medical Coverage (or Payment) CMS-10003-NDMCP

A Medicare health plan ("plan") must complete and issue this notice to enrollees when it denies, in whole or in part, a request for a medical service/item or a request for payment of a medical service/item the enrollee has already received. The notice contains text in curly brackets "{ }" to be inserted, as applicable, as explained in these instructions. The notice also contains text in square brackets "[ ]" that is to be inserted, as applicable, if a plan enrollee receives full benefits under a State Medical Assistance (Medicaid) program and the plan denies a service/item that is subject to Medicaid appeal rights. Bracketed text shown in italics must be inserted in the notice as written when the language applies under state Medicaid rules. Bracketed text that is not italicized provides instruction on text to be inserted in the notice.

The OMB control number must be displayed on the notice. The notice must be provided in 12 point font.

When the Spanish-language version of this notice is used, the Medicare health plan must make insertions on the notice in Spanish. Additional steps need to be taken to ensure that the enrollee comprehends the content of the notice.

Heading

- Date: Insert the month, day, and year the notice is issued.
- Name: Insert the enrollee's full name.
- Member number: Insert the enrollee's plan identification number. The enrollee's HIC number must not be used.

A plan is permitted to insert additional fields of information in the header section of the notice consistent with applicable State requirements, such as the enrollee's Medicaid number, provider name, and date of service.

Section Titled: Your request was denied

The plan must insert the appropriate term to describe the action taken; that is, whether the service was *denied, stopped, reduced* or, in the case of a Medicaid service, *suspended* (temporarily stopping a service). If the denial involves a payment request, the plan must insert the *payment of* text shown in brackets. In the free text field, the plan must clearly and specifically list the denied medical services/items.

Section Titled: Why did we deny your request?

The plan must insert the appropriate term to describe the action taken; that is, whether the service was *denied, stopped, reduced* or, in the case of a Medicaid service, *suspended* (temporarily stopping a service). In the free text field, the plan must provide a specific and detailed explanation of why the medical services/items were denied, including a description of the applicable Medicare (or Medicaid) coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based. A specific explanation about what information is needed to approve coverage must be included.

Plans that provide both Medicare and Medicaid benefits (e.g., integrated Dual Special Needs Plans) should determine if the request for payment or coverage concerns a service or item covered under the plan's Medicare or Medicaid benefits. Plans can make such determinations based on consideration of the following criteria:

- The item or service is identified in plan materials, such as the Evidence of Coverage (Enrollee Handbook), as solely a Medicaid benefit;
- The item or service was previously approved solely under the plan's Medicaid benefits, and the request is for reauthorization or payment for services following such approval (see below for more discussion);
- The service is only covered under the plan's Medicaid benefits and never covered by Medicare and not covered by the MA plan as a supplemental Medicare benefit (Medicaid-only services are generally limited to non-medical services such as Medicaid home- and community-based long term services and supports that the plan is contracted to provide to eligible Medicaid beneficiaries, such as personal care attendants. Integrated plans should work with their states to develop a definitive list of these Medicaid-only services.).

If the request is classified by the plan as a request for payment or coverage under the plan's Medicaid benefits that is fully covered under the plan's Medicaid benefits the IDN should not be sent. If the request is classified as a request for only Medicaid coverage, and the plan denies coverage or payment in whole or in part under the plan's Medicaid benefits, then the plan should send any notices required to meet state Medicaid notice requirements.

When an integrated D-SNP receives a request for payment or coverage that cannot be readily classified falling solely under the plan's Medicaid benefits (e.g., the request is for a service with overlapping Medicare and Medicaid coverage, such as home health services, or the request is not specific enough to classify, such as a request for a home health aide), and the plan determines the item or service is not covered under the plan's Medicare benefits, but is fully covered under the plan's Medicaid benefits, then the plan must send a notice informing the plan enrollee of the denial of Medicare coverage and the relevant Medicare appeal rights. Further, in situations where there is any chance of Medicare coverage, but the plan provides coverage only under the Medicaid benefit, the plan must send a notice informing the plan enrollee of the denial of Medicare coverage and the relevant Medicare appeal rights. The plan must use the IDN to fulfill this requirement and use the free text field to explain that the service/item will be covered under the enrollee's Medicaid benefits (in addition to the required explanation related to the Medicare denial). For example, the free text field could include the following: "Medicare doesn't cover (insert medical service) because (insert detailed rationale). However, since we manage both your Medicare and Medicaid health benefits, we have determined that the service can be covered under your Medicaid benefits and we have authorized coverage for you to receive (insert medical service)."

Section Titled: You have the right to appeal our decision
The plan must insert its name in the {health plan name} field.

If the action taken involves Medicaid benefits, insert text shown in the square brackets, as applicable (include the timeframe for requesting a plan-level appeal for a Medicaid

service, if the State timeframe is more or less than 60 days). If the enrollee is not required to exhaust the plan level appeal before requesting a State Fair Hearing, the notice must inform the enrollee of the right to concurrently request a plan appeal and a State Fair Hearing. The plan must insert applicable timeframes for requesting a State Fair Hearing.

Section Titled: If you want someone else to act for you
The plan must insert the phone and TTY numbers to be used if the enrollee needs information on how to name a representative.

Section Titled: There are 2 kinds of appeals with {health plan name}
Standard Appeal - As applicable, the plan must insert the adjudication timeframe for standard Medicaid appeals.

Fast Appeal - No information to insert. For notice of payment denials, plans may delete this section.

Section Titled: How to ask for an appeal with {health plan name}
In the title to this section, insert the health plan name.

Step 1: If the plan requires the appeal to be in writing, insert the bracketed option of *written*. If the notice relates to a Medicaid service, insert the italicized text shown in the square brackets.

Step 2: In the spaces provided for Standard and Fast Appeals, the plan must insert the plan's address, phone and fax number(s). If the plan accepts standard appeal requests by phone, insert the text shown in brackets. For notice of payment denials, plans may delete the "Fast Appeal" section.

Section Titled: What happens next?
If the denial involves a payment request, insert the *payment of* text shown in brackets. If the notice relates to Medicaid services, insert additional State-specific rules, as applicable.

Section Titled: How to ask for a Medicaid State Fair Hearing/What happens next?
The optional Medicaid text in brackets must be included if the plan manages both Medicare and Medicaid benefits and the service/item is subject to Medicaid appeal rights. If applicable, insert text shown in square brackets if a Medicaid service was denied, stopped, reduced, or suspended. The plan must insert applicable timeframes for State Fair Hearings, as well as address, phone and fax numbers. If the denied medical services/items do not involve Medicaid services, the text related to asking for a State Fair Hearing must not be included in the notice.

Section Titled: Get help & more information
In the spaces provided, the plan must insert the plan's toll free phone and TTY numbers

for the enrollee, physician or representative to call if they need information or help. This section must always be included in the notice, whether or not the notice integrates the text from the preceding section containing bracketed language related to Medicaid State Fair Hearings. If the notice involves a Medicaid service, the plan must insert Medicaid/State contact information. If applicable, the plan should insert state/local disability and aging services contact information.