CMS Response to Public Comments Received for CMS-10003

The Centers for Medicare and Medicaid Services (CMS) received comments from Ancorat Consulting, Blue Cross Blue Shield Association, Prime Therapeutics, and one anonymous commenter related to CMS-10164. This is the reconciliation of the comments.

Comment:

CMS received a comment from Ancorat Consulting suggesting that language stating "If you're asking for an appeal and missed the deadline, you may include the reason for being late", be more specific if CMS' intent is to inform enrollees they may ask for a good cause extension and may include their reason for being late.

Response:

CMS agrees more specific language would be beneficial to the enrollee and has revised the sentence to state "If you're asking for an appeal and missed the deadline, you may request an extension and should include the reason for being late".

Comment:

CMS received a comment from Ancorat Consulting recommending CMS modify a reference to "drugs" in the crosswalk on page 7 to specify "Part B or Medicaid drugs", citing it does not reflect the change made in the form instructions in "Section Titled: Your request was denied".

Response:

CMS has corrected the crosswalk to reflect the change in the form instructions.

Comment:

CMS received comments from Blue Cross Blue Shield Association. Several of the comments were inquiry in nature rather than suggested changes to the actual documentation.

Response:

CMS appreciates the suggestions, concerns and questions expressed by this commenter. Each bulleted item will be addressed individually.

Comment:

1) *"On page 1, the denial letter has been changed to allow an option with additional descriptions of actions performed, including a partial approval. Does a separate approval letter also have to be sent (if applicable) or can that approval language be added as free text?"*

Response:

Thank you for your comment. This question is outside of the scope of this PRA submission. Please submit any policy related questions to the Medicare Part C appeals and grievances resource mailbox, Part_C_Appeals@cms.hhs.gov.

Comment:

2) *"On Page 1 heading, the instructions say that the HIC number cannot be used. Is the UMI still acceptable or should the MBI be used?"*

Response:

On Page 1 of the instructions, under "Heading" language that stated "The HIC number cannot be used" was removed. Plans should insert the enrollee's plan identification number, as indicated on the instructions.

Comment:

3) "On Page 1, section on your appeals was denied, is there a specific date format that is required?"

Response:

Plans may use any date format that includes the month, date, and year. For example, both "01/01/2019" and "January 1, 2019" are acceptable date formats.

Comment:

4) "On page 2, the change allows the member to indicate the reason why they are late with an appeal. Is this a change to the member's rights? Who decides whether the reason for the late appeal would be considered "good cause"?"

Response:

CMS has not changed policy related to member rights. As indicated in the crosswalk, the language was added to inform enrollees they may request an extension from the plan if they miss the deadline for filing an appeal and should include their reason for being late.

Comment:

CMS received a comment from Blue Cross Blue Shield Association stating they believe language on page 3 that reads, "If you ask for an appeal, we will send you another letter with a decision to tell you if we approve or deny your request", may be confusing to a member and they suggest CMS replace with "If you ask for an appeal, we will send you a letter once a decision is made".

Response:

CMS thanks the commenter for identifying potential opportunities to reduce enrollee confusion. Because plans are not required to send notification to an enrollee if their case is forwarded to the Independent Review Entity, CMS has revised this sentence to more accurately reflect what enrollees can expect following an appeal. Please see revised form and crosswalk for specific changes.

Comment:

CMS received a comment from Blue Cross Blue Shield Association suggesting CMS insert curly brackets (i.e. { }) around "phone" as a part of the standard appeal information on page 3, step 2 of the form.

Response:

CMS has accepted this suggestion and thanks the commenter for their feedback.

Comment:

CMS received a comment from Prime Therapeutics advising CMS that the 24-hour fast appeal timeframes for Part B drugs provided in CMS-10003 do not align with 72-hour expedited timeframes for Medicare Part B drugs in Final Rule 84 FR 23832 (42 CFR 422.590(e)), and requests CMS correct or provide clarification on the timeframes.

Response:

CMS thanks you for your comment and has corrected the Part B drug timeframes in CMS-10003.

Comment:

CMS received a comment from Prime Therapeutics suggesting Medicaid language under *"There are 2 kinds of appeals with {health plan name} Standard Appeal"* which states "[Insert timeframe for standard internal plan Medicaid appeals, if different]" also be included in the "*Fast Appeals*" section for plans to populate variable Medicaid timeframes for fast appeals.

Response:

CMS agrees with the commenter's recommendation and has also included language regarding expedited timeframes for Medicaid appeals in the "Fast Appeals" section of the form.

Comment:

CMS received a comment from Prime Therapeutics seeking clarification on whether the IDN is the appropriate notice when there is a chance a drug may be covered under the Medicare Part D benefits, stating there are situations when a drug/item may be covered under Medicare Part D benefit.

Response:

If a Medicare Advantage Prescription Drug (MA-PD) plan receives a coverage determination request, they must take necessary steps to ensure the request is processed and resolved for both Part B and Part D. CMS recently revised the Part D denial notice (CMS-10146) to ensure if an MA-PD denied a drug under Part D, they take the necessary steps to make sure the drug is processed under Part B. If it is covered under Part B and the plan denies, an IDN must be issued.

Comment:

CMS received a comment from an anonymous commenter suggesting CMS allow plans to modify the term "medical service/item or Part B drug or Medicaid drug" for denials of dental services, stating "medical service/item" does not work well for most supplemental dental services.

Response:

CMS thanks the commenter for the suggestion, however, CMS does not believe using the term "medical service" has adverse impact for supplemental dental services as the free-text fields populated by plans provides a more specific description of what is being denied. CMS will keep the term "medical service/item or Part B drug or Medicaid drug".