CMS Response to Public Comments Received for CMS-10146
January 2020

The Centers for Medicare and Medicaid Services (CMS) received comments from various health plans which are impacted by CMS-10146. The following is the reconciliation of the comments.

Comment:
Recommendation: Please add the appeal statement for payment back into the denial notice. This is an important timeframe for a beneficiary, their authorized rep and/or prescriber to understand and in appeals process and is also consistent with language in EOCs under the appeals section(s).

Response:
CMS thanks the commenter for the suggestion and will incorporate the payment timeline back into the notice.

Comment:
We assume that the expiration date of 02/29/2020 will be updated to reflect at least a 2021 expiration date.

Response:
CMS appreciates the commenter's attention to detail. As this date is controlled by the approval process through the Office of Management and Budget (OMB), the notice expiration date will be updated as the notice passes through final clearance.

Comment:
We believe that the deletion of the direct member reimbursement 14 day turnaround time under the standard appeals section was in error. We request that the 2019 verbiage, "If your appeal is for payment of a drug you've already received, we'll give you a written decision within 14 days," be reinstated to avoid any beneficiary confusion for direct reimbursement denials.

Response:
CMS thanks the commenter for the suggestion and will incorporate the payment timeline back into the notice.

Comment:
We support the inclusion of the plan Appeals web link in the denial notice. However, this introduces a new variable field for Pharmacy Benefit Managers (PBMs) who are delegated Medicare Part D coverage determinations and appeals for multiple Medicare plans. In order to ensure that we have adequate time to obtain this information from our clients and change our denial letter programming to accommodate the new information we ask that CMS not hold plan accountable for the use of the updated form until at least July 1, 2020.

Response:
CMS is appreciative that the commenter is willing to adapt to technological changes. It is not CMS's intention at this point that a live web link be added to this notice. CMS has revised this language.

Comment:

UHC supports steps CMS has taken to simplify and reduce the population of duplicative information under section “How Do I request an Appeal?” However, we have concerns that the new proposed placement of the phone number immediately below the “For a Standard Appeal” section could lead to member confusion and drive errant standard verbal appeal requests for plans that do not accept them. UHC recommends a change so that it is clear that phone contact is reserved for expedited appeals for plans that do not accept verbal standard appeals. See possible verbiage below: * For an Expedited (Fast) Appeal: You, your prescriber, or your representative can file an appeal by telephone at <insert phone number>, by fax, through the plan’s appeal website, or by mail as listed below. A verbal request by telephone is the fastest way to file an expedited (fast) request. * For a Standard Appeal: [For plans that accept verbal standard requests:] {You, your prescriber, or your representative can file an appeal by telephone, by fax, through the plan’s appeal website, or by sending a letter to the mailing address listed below.} * [For plans that do not accept verbal standard requests:] {You, your prescriber, or your representative can file an appeal by fax, through the plan’s appeal website, or by sending a letter to the mailing address listed below.} * [Plans that do not accept verbal standard requests omit phone/TTY:] * {Phone: TTY:}

Response:
CMS thanks the commenter for their constructive comment. The notice and instructions have been updated to create more clarity in how beneficiaries can appeal with plans that do not accept standard verbal appeals.

Comment:
Additionally, UHC appreciates CMS’ additional instructions for MAPDs: If the plan determines that the requested drug is typically covered under Part B and instead processes a Part C organization determination, the plan must send the Integrated Denial Notice (CMS-10003) if coverage is denied under Part B (e.g., Part B drug step therapy requirements have not been met).

Response:
CMS is grateful that the changes to the notice regarding drugs requested within MAPDs is seen as helpful.