Form Instructions for the Applicable Integrated Plan Coverage Decision Letter CMS-10716

What types of plans must use this letter?

Dual Eligible Special Needs Plans ("D-SNPs") and affiliated Medicaid managed care organizations (MCOs) that are "applicable integrated plans" must use this letter. "Applicable integrated plans," for the purposes of this letter and corresponding instructions, are fully integrated D-SNPs (FIDE SNPs) or highly integrated D-SNPs (HIDE SNPs) and affiliated MCOs with exclusively aligned enrollment, as defined at 42 CFR 422.561. Applicable integrated plans are hereinafter referred to as "plans" in these instructions.

When should the plan use this letter?

Plans must complete and issue this letter to members when, as a result of an integrated organization determination under 42 CFR 422.631, they reduce, stop, suspend, or deny, in whole or in part, a request for a service/item (including a Medicare Part B drug) or a request for payment of a service/item (including a Medicare Part B drug) the member has already received. This letter must be used in place of the Notice of Denial of Medical Coverage (or Payment) form (CMS-10003-NDMCP).

Plans should not send this letter when the request for a service or item is fully covered by the D-SNP or affiliated MCO, either under the Medicare or Medicaid benefit. Additionally, this letter must not be used for Medicare Part D denials. Plans will continue to use form CMS-10146, Notice of Denial of Medicare Part D Prescription Drug Coverage, for Part D denials.

Formatting and language requirements

- The letter contains text in pointed brackets < > when the plan must insert particular information into the document, and it is:

    1. Based on the specific situation involved – for example, the appropriate term to be inserted depends on the situation, or

    2. Specific to the individual letter – for example, an effective date or deadline date

- Instructions to plans appear in blue italicized text and brackets [ ] and are only for plan use. Plans must ensure that no blue italicized text remains and that blue non-italicized text is changed to black text in the Coverage Decision Letters that plans send to members.

- The OMB control number must be displayed on the letter.

- The letter must be provided in 12-point Times New Roman font equivalent or larger.

- Dates should be written in month, date, year format (for example: May 14, 2021)

- When the letter gives the plan specific choices about word usage (e.g., <service *or* item> <doctor *or* health care provider>), the plan should choose the term that fits the circumstances and use it consistently throughout the notice.

- Any free text insertions should be written in a way that is understandable by a layperson (to the extent possible). The text should:

    1. Be in plain language, including short sentences, bulleted lists where appropriate, and other means of making the information easy to read and understand.

    2. Not consist solely of coding or technical terms, nomenclature, or other system-based or otherwise plan-internal designations.

    3. When using the letter in a non-English language, text insertions in the letter should also be in that non-English language. These insertions should be in plain language and use terminology familiar to the specific Limited English Proficiency (LEP) populations served by the plan. Plans may consult www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html?redirect=/WrittenMaterialsToolkit for more information.

- Plans should take steps to ensure that members can understand the letter, including conducting routine consumer testing of plan language with LEP individuals and modifying language as needed based on testing results.

Required timeframes in this letter

Plans operating in states that have established shorter timelines for a plan to make a decision on an appeal must replace any relevant timeframes with those set by the state. These timeframes must be documented in the plan's state Medicaid agency contract as provided under 42 CFR 422.629(c). This letter includes instructions for timeframes where such replacements are possible.

Heading instructions

- **<Date of Letter>**: Insert the date the letter is issued in month, date, year format.

- [*Insert Member name*]: Insert the member's full name.

- Member Health Plan ID**:** Insert the member's health plan identification number. The member's Medicare Beneficiary Identifier (MBI) should not be used.

- Service/item this letter is about: Insert the name and/or brief descriptor of the service or item that was requested and for which authorization and/or payment is being denied.

- [*Insert additional field(s) as needed or when required by state, such as provider or Member Medicaid ID*]**:** The plan is permitted to insert additional fields of information in the header section of the letter if needed, consistent with applicable state requirements,

such as the name of the provider making the request or the member's Medicaid number. If the plan operates in a state that requires contracted plans to include additional fields in this heading, add those fields.

First paragraph of letter

- In the first sentence of this paragraph, insert the plan name.
- In the second and third sentences of this paragraph, replace "Medicaid" with the state-specific term for Medicaid, if applicable. If the state-specific term does not include the word "Medicaid," plans should add "(Medicaid)" after the first use of the state-specific term.

Second paragraph of letter

The plan should insert in bold text the appropriate terms in the fields listed in this paragraph to describe the action taken; that is, whether the service was denied, partially denied, reduced, stopped, or, in the case of a Medicaid service, suspended (temporarily stopping a service). If the denial involves a payment request, insert the "payment for*"* text shown in the blue instruction to the plan.

Below the second paragraph:

- In the description of the service/item being denied, partially denied, reduced, stopped, or suspended, the plan should, in plain language, clearly and specifically list the medical services/items affected.
    - If the plan suspends a service, the plan should explain what "suspended" means and whether the benefit is suspended permanently or for a particular time period.
    - If a benefit is reduced, the plan should specify the new amount of the service permitted.

Third paragraph of letter

In the sentence that begins, "Our plan made this decision because," the plan should provide a specific denial reason and a concise explanation of why the service/item was denied and include state or federal law and/or *Evidence of Coverage/Member* or *Enrollee Handbook* provisions and plan policies/procedures or assessment tools used to support the decision.

- This explanation should be in plain language and give, at a minimum, a basic explanation of the reasoning behind the action in the simplest language possible without losing meaning. It should also include a specific explanation about what information is needed to approve coverage.

- Plans may provide a brief description of any Medicare or Medicaid coverage rule or plan policy included in the explanation. If the plan considered both Medicare and Medicaid coverage rules in making its decision, the description should include both sets of rules.
- Plans are encouraged to include a brief explanation of how the determination to discontinue or reduce coverage was made. If the plan considered both Medicare and Medicaid coverage rules, the explanation should describe how both coverage rules were applied in this case.
- If the denial is for a Medicaid service/item that is not covered by the plan but is covered by another payer, such as a specific behavioral health service, the explanation should instruct the member how to obtain coverage by providing contact information for the covering payer. The explanation should also offer to help the member seek coverage for the service/item and provide contact information for where such assistance can be obtained.

Fourth paragraph of letter

In the sentence that states "Our plan will <reduce *or* stop *or* suspend> your <service *or* item> on <effective date>," the plan should insert the effective date of the decision if the decision resulted in a stoppage, suspension, or reduction of a service/item the individual has already been receiving. The effective date should be at least 10 days after the date the letter was issued or a longer period if required by the state. If the decision is in regard to a service/item that has not yet been received (for example, the denial is for a request for prior authorization), the plan should remove this sentence.

Section titled: You have the right to appeal our decision

The plan should insert the proper term ("doctor," "health care provider," "service," or "item") in each instance of pointed brackets in this section, based on whether a doctor or other health care provider ordered the service/item described in the letter and whether the denial is for a service or item.

In the second paragraph, the plan should insert the most appropriate plan phone and TTY numbers for appeal requests. The plan may insert the toll-free Member Services phone number and toll-free TTY number if the plan doesn't have a specific phone number for appeal requests.

In the "You must appeal by" sentence, the plan should insert the appeal filing deadline date in the field indicated by the blue instruction to the plan. The appeal filing deadline date is 60 calendar days from the date of the letter. For example, if the letter is dated March 15, the Date of Letter will be March 15, and the appeal filing deadline date will be May 14. The plan should enter the deadline in month, date, year format. The plan should insert the deadline in bold text.

Section titled: There are two kinds of appeals

Throughout this section, the plan must insert "7 calendar days" if the item is a Part B drug or "30 calendar days" for all other services or items, as indicated in the blue instruction to the plan. Plans operating in states with shorter timelines to make a decision on an appeal must replace any relevant timeframes with those established by the state and documented in the state Medicaid agency contract.

Throughout this section, the plan should insert proper terms ("doctor" or "health care provider") as indicated by the fields with pointed brackets, based on whether a doctor or other health care provider ordered the service described in the letter.

The plan should delete the last paragraph in this section when this letter is for a denial of a Part B drug.

Section titled: How to appeal

Throughout this section, the plan should insert the proper term ("doctor," "health care provider," "service," or "item") in each instance of pointed brackets, based on whether a doctor or other health care provider ordered the service/item described in the letter and whether the denial is for a service or item.

The plan should insert the most appropriate plan phone and TTY numbers, fax number, mailing address, and, if appropriate, the in-person delivery address that members may use to file an appeal. The plan may insert the toll-free Member Services phone number and toll-free TTY number if the plan doesn't have a specific phone number for appeal requests.

In the paragraph that starts, "To get more information on how to appeal," the plan must insert the plan's toll-free Member Services phone number in the <toll-free plan Member Services phone number> field and toll-free TTY number in the <toll-free TTY number> field. If the plan does not use the term "Member Services," the plan should replace it with the term they use. The plan should insert the term "*Evidence of Coverage*," "*Member Handbook*," "*Enrollee Handbook*," or other term the plan uses in the fields indicated by the blue instruction to the plan. In the second sentence, the plan may also include additional chapter and/or section reference information, as applicable. In the third sentence, the plan should also insert the website where members can access the most current version of the plan's *Evidence of Coverage*/*Member* or *Enrollee Handbook* document in the <web address> field. The plan may include a QR code along with the web address.

Section titled: How to keep getting your <service *or* item> during your appeal

Throughout this section, the plan should insert the proper term ("service," "item," "doctor," or "health care provider") as indicated in the fields with pointed brackets.

The plan should insert the continuation of benefits request deadline date in the fields indicated by the blue instruction to the plan. The continuation of benefits deadline date is one of the following, whichever is later:

- 10 calendar days from the date of the letter (or later than 10 calendar days, if required by the state)
- The effective date of the decision

The continuation of benefits request deadline date should be inserted in month, date, year format and, for the first instance, in bold text.

Section titled: What happens next

If the denial involves a payment request, insert the "payment for" text shown in the blue instruction to the plan. The plan should insert the proper term ("service" or "item") as indicated in the fields with pointed brackets, based on whether the denial is for a service or item. The plan should insert the state name as indicated in the fields with pointed brackets. If the state uses a different term for Fair Hearing, the plan may insert the state-specific term in parentheses as indicated in the blue instruction to the plan.

Section titled: What to do if you need help with your appeal

In the first bullet in this section, the plan should insert the most appropriate plan phone and TTY numbers in the fields with pointed brackets to be used if the member needs information on how to name an authorized representative for the purposes of the appeal. The plan may insert the toll-free Member Services phone number and toll-free TTY number if the plan doesn't have a specific phone number for authorized representative requests. The plan may also replace the Medicare.gov web address with a plan-specific web address that explains how members can appoint a representative.

In the third bullet in this section, the plan should insert, in the appropriate fields, the mailing address and fax number that may be used to submit authorized representative requests.

Section titled: Get help and more information

- The plan should insert its name in the <plan name> field, the plan's Member Services toll-free phone and TTY numbers, along with days and hours of operation, for the member, doctor, health care provider, or representative to call if they need information or help with the appeal process in the appropriate fields, as designated by pointed brackets. If the plan does not use the term "Member Services," the plan should replace it with the term they use. The plan should also insert the plan's web address in the <plan website> field. The plan may use the web address that provides information about the plan's appeals process. The plan may include a QR code along with the web address.
- If the state uses an Ombudsman or other member support program, the plan should insert the name and contact information for the Ombudsman or other member support

program in the appropriate field. If the state doesn't use an Ombudsman or other member support program, this bullet should be removed.

- The plan should insert in the appropriate field the state-specific name and contact information for the SHIP program in the state.
- The plan should insert "Medicaid" or the state-specific name for the Medicaid agency and contact information in the appropriate field.
- If applicable, the plan should also insert the name(s) and contact information of any other state/local disability and aging services agency(ies) that provide(s) unbiased assistance with plan appeals.

End of Document

At the end of the letter, the plan should include information on how to get the letter for free in non-English languages or alternate formats, including the plan's toll-free phone and TTY numbers and days and hours of operation. Plans should insert the languages that they are required to translate as indicated in the field with pointed brackets.