30-day Federal Register Crosswalk: High Level Summary of Revisions

We made minor updates to the coverage decision letter based on comments received during the 60-day review period. The coverage decision letter is issued to applicable integrated plan enrollees when a request for a service or item is denied. The changes will not result in additional burden.

Section	**Change/Reason**
Throughout the document	We updated fields throughout the letter that read "<service or item>" to "<medical service/item or Medicare Part B drug or Medicaid drug>" for consistency with language used in the Medicare Advantage and Medicare-Medicaid plan integrated denial notices.
Header	We realigned the contact information field under the title from centered justified to left justified for readability.
Fourth Paragraph	We added a sentence to inform the reader there is more information further down in the letter on how to request a continuation of services during appeal. We included the following sentence: "See the 'How to keep getting your <medical service/item *or* Medicare Part B drug *or* Medicaid drug> during your appeal' section later in this letter for information about continuing to receive your <medical service/item *or* Medicare Part B drug *or* Medicaid drug > during your appeal."
Section titled: You have the right to appeal our decision	We added the language "to our plan" to clarify that the appeal is filed with the plan. The sentence now reads: You must appeal to our plan by [Insert specific appeal filing deadline date in month, date, year format – 60 calendar days from date of letter. Insert deadline date in bold text].
Section titled: There are two kinds of appeals	We deleted the following statement: Note: You can't get a fast appeal if our plan denied payment for a service you already got. This statement is inconsistent with our guidance in the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans, sections 50.1.a and 50.7.1.a that allow expedited reconsiderations for payment denials.
Section titled: There are two kinds of appeals	We added instructional language to allow plans to remove the extensions language if a state does not allow extensions for appeals.
Section titled: How to keep getting your medical	We added instructions to plans that make it optional to remove this section. Plans may include this section even if the decision does not relate to a service/item/drug that was approved under a previous authorization.

service/item or Part B drug or Medicaid drug during your appeal	
End of document	To the end of the letter, we added a new nondiscriminatory language disclaimer that is required on CMS forms and notices.