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, Part B or Medicaid drug or a request for payment of a medical service/item or Part B or Medicaid drug 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 medical service/item or Part B or Medicaid drug 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.

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: Coverage for your medical services/items was ~~Your request was~~ {Insert appropriate term: partially approved, denied}

The plan must insert the appropriate term in the title and body of this section to describe the action taken; that is, whether the service was *denied, partially approved, 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 or Part B or Medicaid drugs. For stopped, reduced or suspended services, include the date the decision will take effect.

Section Titled: Why was coverage {Insert appropriate term: denied, partially approved, stopped, reduced, suspended}?~~Why did we deny your request?~~

The plan must insert the appropriate term in the title and body of this section to describe

the action taken; that is, whether the service was *denied, partially approved, 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 or Part B or Medicaid drugs 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.

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Plans that provide both Medicare and Medicaid benefits[1] (e.g., integrated Dual Special Needs Plans) should determine if the request for payment or coverage concerns a medical service/item or Part B or Medicaid drug covered under the plan's Medicare or Medicaid benefits. Plans can make such determinations based on consideration of the following criteria:

- The medical service/item or Part B or Medicaid drug is identified in plan materials, such as the Evidence of Coverage (Enrollee Handbook), as solely a Medicaid benefit;
- The medical service/item or Part B or Medicaid drug 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 service/item or Part B or Medicaid drug 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

[1] Effective January 2021, other plans that provide both Medicare and Medicaid benefits that are "applicable integrated plans" under 42 C.F.R. § 422.561 should follow the notice requirements for integrated organization determinations and reconsiderations under 42 C.F.R. §§ 422.629 through 422.634.

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 or Part B or Medicaid drug 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. 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.

D-SNPs must offer to assist an enrollee with obtaining Medicaid covered services. This includes requesting authorization of Medicaid services, as applicable, and navigating Medicaid appeals or providing documentation to support a request for a Medicaid appeal, in connection with the enrollee's own Medicaid coverage, regardless of whether such coverage is in Medicaid fee-for-service or a Medicaid managed care plan. D-SNPs insert text shown in square brackets.

If the enrollee accepts the D-SNP's offer of assistance, the plan must provide the assistance. Examples of such assistance include:

- Explaining to an enrollee how to make a request for Medicaid authorization of a service or how to file an appeal following an adverse benefit, such as
    - Assisting the enrollee in identifying the enrollee's specific Medicaid managed care plan or fee-for-service point of contact;
    - Providing specific instructions for contacting the appropriate agency in a fee-for-service setting or for contacting the enrollee's Medicaid managed care plan, regardless of whether the Medicaid managed care plan is affiliated with the enrollee's D-SNP; and
    - Assisting the enrollee in making the contact with enrollee's fee-for-service contact or Medicaid managed care plan.
- Assisting a beneficiary in filing a Medicaid grievance or Medicaid appeal.
- Assisting an enrollee in obtaining documentation to support a request for authorization of Medicaid services or a Medicaid appeal.

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}
In the title to this section, insert the health plan name.

Standard Appeal –

- Request for Service: As applicable, the plan must insert the appropriate adjudication timeframe for Medicare medical services/items or Part B drugs, or standard Medicaid appeals. If the request is for a medical service/item, the plan must insert the bracketed language related to extensions.
- Request for Payment: The plan must insert whether the payment request is for a medical service/item or Part B drug.

Fast Appeal - As applicable, the plan must insert the appropriate adjudication timeframe ~~for medical services/items or Part B or Medicaid drugs~~.

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 and/or electronically, insert the text shown in brackets.~~

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?
The optional Medicaid text in brackets must be included if the plan manages both Medicare and Medicaid benefits and the service/item or Part B or Medicaid drug is subject to Medicaid appeal rights. If applicable, insert text shown in square brackets if a Medicaid service was denied, partially approved, 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

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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.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0829. This information collection is for the notice Medicare health plans must provide when a request for either a medical service or payment is denied, in whole or in part. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1852(g)(1)(B) of the Act and the regulatory authority set forth in Subpart M of Part 422 at 42 CFR 422.568, 422.572, 417.600(b), and 417.840. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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