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Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals – The Eleventh in the MLN Matters Series on the New Prescription Drug Plans

Note: This article was updated on October 1, 2012, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

All health care professionals who prescribe prescription medications for Medicare beneficiaries

Impact on Providers

The new Medicare prescription drug coverage began on January 1st. Already, pharmacists have filled millions of prescriptions for people with Medicare. During this important transition period to the new prescription drug coverage, the Centers for Medicare & Medicaid Services (CMS) understands that there is much that prescribing health care professionals need to know about this new coverage in order to help their Medicare patients.

Essential Information for Prescribing Health Care Professionals

CMS has compiled a list of information, resources, and tools that will allow health care professionals and their support staff to help their Medicare patients during this transition period.

Finding Formulary Information

CMS has a formulary finder that provides direct access to all plan websites at <https://www.medicare.gov/find-a-plan/questions/home.aspx> on the web. In addition, we have worked with Epocrates to provide free software which makes the

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formulary selection process very simple. You can load this program into your PDA or run the software on a desktop. This tool is available at <http://www.epocrates.com/> on the web.

Coverage Determination

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

CMS does not have the authority to mandate a standard exception process for each Medicare drug plan or MA-PD; however, the Agency is working to simplify the exceptions process. Like typical commercial payers, health care professionals may occasionally need to help a patient file a prior authorization for a medication or appeal a medication's tier. CMS is working with medical specialty societies to address these issues.

A form has been created by a coalition of medical societies and advocacy groups that can be faxed to your office by a pharmacist when he or she is given a prescription that is either not on the formulary or on a higher tier.

This form streamlines communication between the pharmacist and the physician and reduces the need for time consuming telephone calls to the doctor's office.

The form is located at

<http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/PartDPharmacyFaxForm.pdf> on the CMS website, as well as at several medical society websites.

Expedited Review Process

There is an expedited review process that CMS has outlined to ensure that drug plans can move an appeal quickly, i.e., within a 24-hour turnaround time, to provide medicines to patients with an immediate need. Beyond this expedited review process, the standard appeals process to challenge a plan's coverage determination has five levels:

- Redetermination by the plan;
- Reconsideration by a Medicare drug coverage qualified independent contractor (QIC);
- An Administrative Law Judge (ALJ) hearing;

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- Review by the Medicare Appeals Council; and
- Review by federal district court.

Visit <http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html?redirect=MedPrescriptDrugApplGriev/> for a list of plan contacts you can use to query your patient's plan should you need to pursue an appeal or require clarification on an issue.

Part B Drugs vs. Drugs Covered under Medicare Prescription Drug Coverage (Part D)

A previous MLN Matters article explains the difference between drugs covered under Part B versus those covered under Part D.

This article can be found at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0570.pdf> on the CMS website. Additionally, a chart explaining specific drugs can be found at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/BvsDCoverageIssues.pdf> on the CMS website.

Verifying Beneficiary Enrollment in a Medicare Drug Plan

Office staff can use the Medicare Prescription Drug Plan Finder, located at <https://www.medicare.gov/find-a-plan/questions/home.aspx>, to verify a beneficiary's enrollment in a Medicare drug plan. By entering all information provided on a beneficiary's Medicare card, the Plan Finder will identify the plan in which the beneficiary is enrolled.

Pharmacists have access to a new computer tool called "E1" that provides real time enrollment and eligibility information. This tool provides both eligibility and billing information at the point of sale and is constantly updated by CMS.

Obtaining Prior Authorizations

A prior authorization can only be obtained by calling the drug plan directly. 1-800-MEDICARE cannot process a prior authorization.

Ensuring Coverage for a Dual Eligible Beneficiary Who Needs to be Enrolled in a Plan

CMS has ensured that people with Medicare and full Medicaid benefits (full dual) will have drug coverage by enabling customer service representatives at 1-800-MEDICARE to enroll these beneficiaries in WellPoint, a national plan.

If these beneficiaries have **immediate prescription needs**, they should visit their local pharmacies. The pharmacist can enroll them in WellPoint at the pharmacy.

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Providing a 90-day Supply of Transitional Prescription Medication

CMS has instructed all Medicare-approved plans to extend the original 30-day transitional coverage period by an additional 60 days. This means that a Part D beneficiary will be able to get a 90 day supply of all of his or her medications when they enroll in Part D, even if some of the medications are not on formulary. This 90 day period will give the patient's doctor and pharmacist time to adjust the patient's drug regimen, or request exceptions to the plan's formulary, so that the next refill of medications will be consistent with the plan's coverage rules. Beneficiaries who enroll after March 31st will get a 30 day transitional fill so that they have time to adjust their medication regimen to the plan formulary.

Important Contact Information to Report Problems with Medicare Prescription Drug Coverage

Health Care Professionals: E-mail pmit@cms.hhs.gov with problems and issues encountered. Please take advantage of CMS' regular conference call at 2PM EST every Tuesday. This call gives health care professionals an opportunity to ask questions of CMS staff. Call 1-800-619-2457; Passcode: RBDML.

Pharmacists: Call 1-866-835-7595, a CMS dedicated line designed to help answer questions regarding billing and beneficiary enrollment information.

Additional Information

Health care professionals can visit <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html> on the CMS website. The redesigned web page contains all the latest information on Medicare prescription drug coverage.

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