MedicareRx
Prescription Drug Coverage

Coverage Determinations and Appeals

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Part D Rights and Protections

- Important for enrollees
  - Smooth transition process
  - Exception and appeals processes
    - Accessible
    - Streamlined
  - Understanding roles
    - Member
    - Physician
    - Pharmacy

Overview

- Coverage determinations
  - Initial decision by plan
    - About benefits an enrollee is entitled to receive or
    - Amount, if any, enrollee is required to pay for a benefit
  - Exception requests are one type
- Appeals
  - Five levels after plan's initial coverage determination

Exception Requests

- Type of coverage determination
- Criteria established in regulation
  - Plans may establish additional exceptions criteria
- Require a supporting statement from physician
  - Not required for other types of coverage determinations
  - May be made orally and in writing

Types of Exceptions

- Two types
  - Tiering exception
    - Allows enrollees to obtain non-preferred drug at more favorable cost-sharing terms applicable to drugs in the preferred tier
    - Can't ask for tiering exception to plan's generic tier
    - Plans may exclude drugs on a specialty tier
  - Formulary exception
    - Ensures access to medically necessary Part D drugs not on plan's formulary
    - Includes exceptions to cost utilization management tools
      - Dosage, quantity limits, some prior authorizations

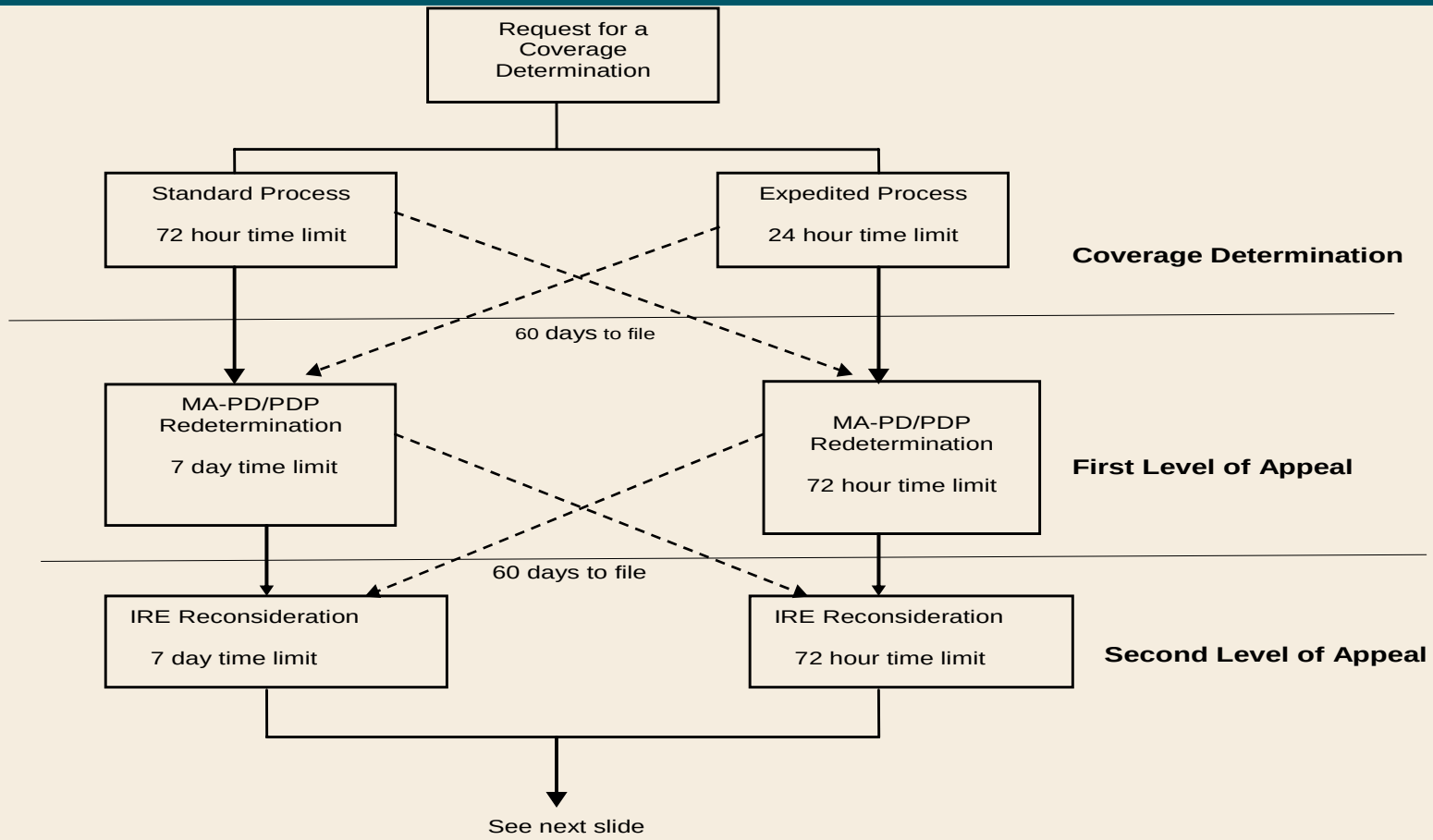
Approved Exceptions

- Exception is valid for refills for remainder of plan year, as long as
  - Beneficiary remains enrolled in the plan
  - Physician continues to prescribe the drug
  - Drug remains safe for treating the enrollee's condition

Coverage Determinations and Appeals

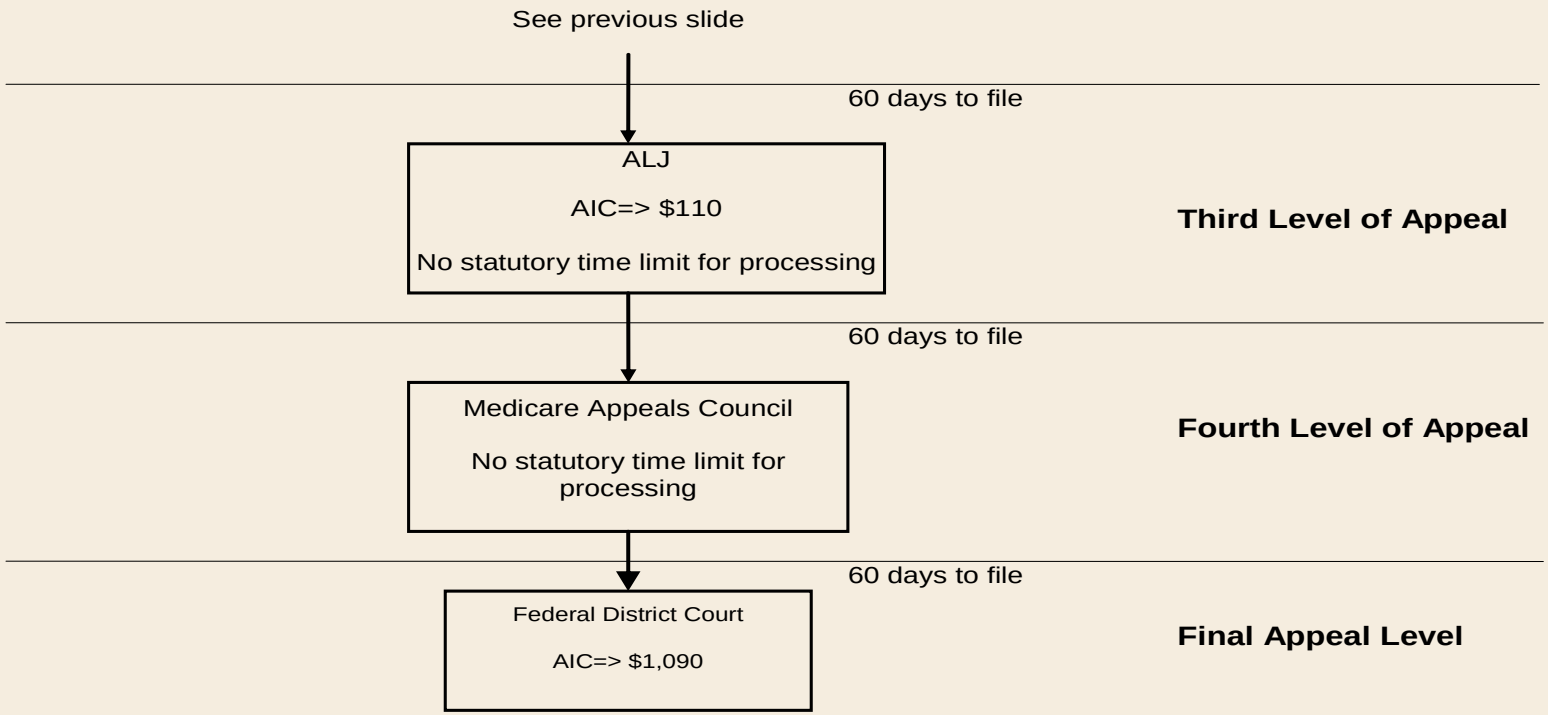
- Part D processes modeled on MA processes
- Key differences
  - Shorter adjudication timeframes
  - No adjudication timeframe extensions
  - No automatic forwarding of adverse redeterminations
    - Except if plan fails to meet adjudication timeframe
    - Enrollee needs to request next step of process in most cases

Coverage Determination & Appeals Process



IRE = Independent Review Entity
MA-PD = Medicare Advantage plan that offers Part D benefits
PDP = Prescription Drug Plan

Coverage Determination & Appeals Process *(continued)*



AIC = Amount in controversy
ALJ = Administrative Law Judge

Coverage Determination
Adjudication Timeframes

- Initial coverage determination request
  - Standard determinations—plan has 72 hours
  - Expedited determinations—plan has 24 hours
- Clock starts when
  - Plan receives doctor's supporting statement (exception request)
  - Plan receives request (other coverage determinations)
- If plan fails to meet timeframes
  - Plan must forward case to Part D QIC
    - QIC is the Independent Review Entity (IRE)
    - Skips the redetermination step

Coverage Determination
Expedited Requests

- If applying the standard timeframe may seriously jeopardize
  - Life or health of the enrollee or
  - Enrollee's ability to regain maximum function
- If doctor indicates or supports medical necessity
  - Must be expedited
- If beneficiary indicates medical necessity
  - Plan decides

Requesting a Coverage Determination or Appeal

- Beneficiary can request all
- Appointed representative
  - Can request all
  - Must have CMS form or equivalent completed or
  - Be an authorized representative (e.g., power of attorney)
- Prescribing physician can request
  - Expedited and standard coverage determinations
  - Expedited redeterminations
  - For other requests, prescribing physician must be appointed representative
- Others can assist with
  - Form completion
  - Letter writing, etc.

Disclosure of Protected Health Information (PHI)

- Plan may disclose relevant PHI to those identified by the beneficiary as being involved in his/her care or payment
  - Family member or other relative
  - Close personal friend
  - Others (see examples on next slide)
- Plan may disclose relevant PHI to those identified by the beneficiary only under the following conditions
  - When the beneficiary is present and agrees/does not object or the plan reasonably infers from the circumstances that the beneficiary does not object
  - When the beneficiary is not present or is incapacitated, the plan may exercise its professional judgment to determine whether disclosure is in the beneficiary's best interests

When Plan May Disclose PHI
Examples

- To beneficiary's daughter
  - Resolving claim or payment issue of hospitalized mother
- To human resources representative
  - If beneficiary is on the line or gives permission by phone
- To Congressional office or staffer
  - That has faxed the beneficiary's request for Congressional assistance
- To CMS staff
  - If information satisfies plan that the individual requested CMS assistance

Requesting a Coverage Determination

- Oral or written
  - Plan **must** accept written requests in all cases
    - May accept oral requests for standard cases
  - Plan **must** accept oral requests for
    - Expedited coverage determinations
    - Expedited redeterminations
  - Coverage determination request form
    - Model form
    - Plan can use or modify
    - Plan must accept any written request containing the necessary information
- If unfavorable decision, enrollee can begin appeal process

Appeals – Level 1

- Appeal through the plan
- Called a redetermination
  - Request within 60 calendar days
    - Extension for good cause
  - In writing
    - Unless plan accepts requests by phone
    - Plan must accept oral requests if expedited
  - Plan must notify appellant of decision
    - Standard request within 7 days
    - Expedited request within 72 hours
  - No minimum dollar amount required

Appeals – Level 2

- Review by an independent review entity
  - Part D QIC
- Called a reconsideration
  - Request within 60 days
    - Extension for good cause
  - Must be in writing
    - CMS creating model form
  - Plan must notify appellant of decision
    - Standard request within 7 days
    - Expedited request within 72 hours
  - No minimum dollar amount required

Appeals – Level 3

- Hearing with an Administrative Law Judge
  - Request within 60 days
  - Must be in writing
- ALJ will notify appellant of decision
- Amount in controversy (projected value of denied coverage) must be $110 or greater

Appeals – Level 4

- Review by the Medicare Appeals Council (MAC)
  - Request within 60 days
  - Must be in writing
  - Form available

    http://www.hhs.gov/dab/DAB101.pdf
- MAC will notify appellant of decision

Appeals – Level 5

- Review by Federal District Court
  - Request within 60 days
  - Must be in writing
- Amount in controversy must be $1,090 or greater

Notices

- Standardized notices
  - All plans must use same notice
- Model notices
  - Plans can use model or modify it
- All denial notices
  - After every coverage determination or appeal
  - Will include information on next appeal level

Standardized Notices

- Pharmacy Notice
  - Provided at pharmacy if coverage denied
  - May be distributed or posted
- Notice of Denial of Medicare Prescription Drug Coverage
  - Provided to beneficiary by plan
  - When coverage determination denied

Model Notices

- Coverage Determination Request Form
  - Can be used for any coverage determination request
    - Including an exception request
- Redetermination Notice
  - Provided to beneficiary by plan
  - When redetermination (1st level appeal) denied
- Notice of Case Status
  - Provided to beneficiary by plan
  - When plan fails to meet timeframes for coverage determination
    - Case automatically forwarded to QIC/IRE (2nd level appeal)

Model Coverage Determination Request Form

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations)

Enrollee's/Requestor's Information

Enrollee's Name

Enrollee's Date of Birth

Enrollee's Medicare Number

Enrollee's Part D Plan ID Number

Requestor's Name (if not enrollee)

Requestor's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

Enrollee/Requestor's Address City State Zip Code

( )
Phone

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

Prescribing Physician's Information

Name

Medical Specialty

Address City State Zip Code

( )
Work Phone

( )
Fax

Office Contact Person

Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*

☐ I request prior authorization for the drug my doctor has prescribed.

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.**

Additional information we should consider *(attach any supporting documents)*:

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

☐ I need an expedited coverage determination (attach physician's supporting statement, if applicable)

Beneficiary/Requestor's Signature

Date

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.

Resources

- Enrollment and Appeals Guidance

  http://www.cms.hhs.gov/PrescriptionDrugCovContra/06_RxContracting_EnrollmentAppeals.asp

- "How to File a Complaint, Coverage Determination, or Appeal"

  http://www.medicare.gov/Publications/Pubs/pdf/11112.pdf

Resources *(continued)*

- Coverage Determination Request Form (model)

  http://www.cms.hhs.gov/prescriptiondrugcovgenin/04_formulary.asp

- Pharmacy Notice and Coverage Denial Notice (both standardized)

  http://www.cms.hhs.gov/PrescriptionDrugCovContra/06_RxContracting_EnrollmentAppeals.asp#TopOfPage

For More Information

- Contact drug plan with questions about coverage
- Talk to doctor
  - About safe and effective alternative drugs
  - To request a coverage determination if necessary
- Call State Health Insurance Assistance Program (SHIP)
  - Call 1-800-MEDICARE (1-800-633-4227) for SHIP telephone number
  - TTY users should call 1-877-486-2048
- Providers visit www.cms.hhs.gov/center/provider.asp

Thank You for Your Attention!

- This training will be available after the broadcast

  http://media.cms.hhs.gov/cms/partner03242006.wma