CDAG/ODAG: Updates and Reminders

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Part D Coverage Determinations, Appeals & Grievances (CDAG)
Part C Organization Determinations, Appeals & Grievances (ODAG)

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Learning Objectives

- Provide an overview of recent updates related to the Medicare Advantage and Part D program coverage determination, appeal and grievance processes
- Address key audit and compliance findings and issues that have been recently or repeatedly identified, or about which CMS has received requests for clarification from MAOs and/or Part D plan sponsors
- Remind MAOs and Part D plan sponsors of various appeals and grievance program requirements to assist them in compliance efforts and minimize delays or denials of beneficiary access to covered drugs or services and the Medicare appeals process

Part D CDAG Updates

- Most recent version of Chapter 18 of the Part D Manual released February 2013
- Part D standardized denial notice currently in process for OMB renewal
  - 60 and 30 day public comment periods have closed
  - Final revised notice will be announced through HPMS once OMB authorizes the renewal

Part D CDAG-Reminders Exceptions vs. PA Requests

Key Audit Finding(s)/Compliance Issue(s):

- Non-compliance with adjudication timeframes
- Failure to effectuate exception approvals through end of the plan year

Part D CDAG-Reminders Exceptions vs. PA Requests (cont.)

Program Requirement(s):

- Plans must have a process in place for reviewing all requests to determine if they involve an exception (tiering or formulary)
- Tolling is only permitted when ALL of the following are true:
  - Exception request
  - No prescriber's statement received
  - Coverage Determination level

Part D CDAG-Reminders Exceptions vs. PA Requests (cont.)

Program Requirement(s):

- Requests that do not involve an exception (e.g., enrollee is attempting to demonstrate that they meet the PA or other UM criteria) must be processed within required timeframes
- Approved exception requests must be through the end of the plan year

Part D CDAG-Reminders Dismissals

Key Audit Finding(s)/Compliance Issue(s):

- Inappropriate dismissals of (including failure to process) coverage determination and appeal requests

Part D CDAG-Reminders Dismissals (cont.)

Program Requirement(s):

- Generally, we expect plans to adjudicate all coverage requests on the merits and to do so within the required timeframes and with an appropriate denial or approval notice
- If an enrollee or prescriber asks for a coverage determination for a formulary drug with no UM criteria, the plan should process as a favorable CD rather than dismiss or fail to process the request

Part D CDAG-Reminders Dismissals (cont.)

Program Requirement(s):

- If an enrollee or prescriber asks for coverage subsequent to an adverse coverage determination but the 60-day appeal timeframe has passed and there is no good cause for untimely filing, the plan should process the request as a new coverage determination rather than dismiss

Part D CDAG-Reminders
B vs. D Coverage Determinations

Key Audit Finding(s)/Compliance Issue(s):

- Failure to appropriately determine coverage under Part B vs. Part D

Part D CDAG-Reminders
B vs. D Coverage Determinations (cont.)

Program Requirement(s):

- CMS expects sponsors—through their pharmacy help desk—to work closely with network pharmacies to resolve B vs. D payment questions at the pharmacy counter to eliminate delays in new therapy starts or interruptions of current therapy

Part D CDAG-Reminders
B vs. D Coverage Determinations (cont.)

Program Requirement(s):

- For B vs. D PAs that go through the CD process, we also expect plans to aggressively solicit clinical information necessary to determine coverage for these drugs
- All coverage decisions must be made as expeditiously as the enrollee's health condition requires

Part D CDAG-Reminders
B vs. D Coverage Determinations (cont.)

Best Practices:

- MA-PD plans are strongly encouraged to establish processes to coordinate Part B and Part D benefits
- MA-PD plans that deny requests for drug coverage under Part D because they have determined that coverage is available under Part B should establish processes to ensure authorization under the Part B benefit and notify enrollees

Part D CDAG-Reminders
B vs. D Coverage Determinations (cont.)

Best Practices (cont.):

- MA-PD plans may use the free text field in the Part D denial notice to include notification that the requested drug is approved and authorized under Part B

Part D CDAG-Reminders Misclassification

Key Audit Finding(s)/Compliance Issue(s):

- Complaints improperly classified as grievances or inquiries when they should have been processed as coverage determinations or redeterminations

Part D CDAG-Reminders Misclassification (cont.)

Program Requirement(s):

- Plans must determine whether an enrollee or prescriber's request is a request for coverage, a grievance, or both
- Complaints must be categorized on a case-by-case basis as determined by the facts and circumstances of each request

Part D CDAG-Reminders Misclassification (cont.)

Program Requirement(s):

- Plans are required to accept verbal and written coverage determination requests from enrollees and prescribers
- Enrollees are not required to use “magic words” or specific forms to request an initial coverage determination or redetermination

Part C ODAG Updates

Integrated Denial Notice (IDN)

CMS announced the new MA standardized denial notice via HPMS on August 13, 2013 which:

- Replaces and consolidates Part C denial notices (Form CMS-10003-**NDP** and Form CMS-10003-**NDMC**), and integrates Medicaid appeal rights, as applicable
- Medicare health plans are required to issue the IDN no later than **November 1, 2013**
- Plans must remove any non-applicable Medicaid State Fair Hearings information from the form before issuing

Part C ODAG-Reminders
Favorable Pre-service OD Notice Requirements

Key Audit Finding(s)/Compliance Issue(s):

- Failure to notify enrollee upon favorable organization determinations

Part C ODAG-Reminders
Favorable Pre-service OD Notice Requirements (cont.)

Program Requirement(s):

- When a party submits a request for service, and the MAO decides to cover the service in full, the plan must notify the enrollee of its favorable organization determination
- CMS does not prescribe the form or manner in which a plan communicates favorable decisions (Note: written notices must go through appropriate marketing review)
- Favorable notification may be provided either verbally or in writing
- The provision of an item or service by a contract provider constitutes a favorable OD. MAOs/contract providers are not currently required to notify the enrollee (other than by provision of the item or service), but enrollees cannot be held liable for these items or services beyond applicable cost-sharing

Part C ODAG-Reminders Denial Notices

Key Audit Finding(s)/Compliance Issue(s):

- Insufficient denial rationale included on Medicare standardized denial and appeals notices

Program Requirement(s):

- MAOs must provide a detailed explanation of the reason they denied the request
- The denial rationale must be specific to the individual's case and written in a manner that an enrollee could understand

Part C ODAG-Reminders
Notice to Contract Providers

Key Audit Finding(s)/Compliance Issue(s):

- Inappropriate issuance of standardized denial notice with appeal rights upon denial of payment to contract providers

Part C ODAG-Reminders
Notice to Contract Providers (cont.)

Program Requirement(s):

- A contract provider does not have appeal rights under the Subpart M appeals process
- Payment denials for contract providers should result in no member liability beyond applicable cost-sharing
- MAOs must *not* issue the standardized denial notice to enrollees or providers for *contract* provider payment denials
- Contract providers who wish to appeal an MAO's denial must refer to their plan contract to determine any available course of action

Part C ODAG-Reminders
Additional Subpart M Requirements

- Under the appeals process set forth in 42 CFR Part 422, Subpart M, a party (an enrollee, the enrollee's representative or a non-contract provider who has agreed to waive enrollee liability beyond applicable cost-sharing) may request a reconsideration (1st level appeal) from the MAO
- A physician who is providing treatment to an enrollee may request a standard reconsideration of a pre-service request on the enrollee's behalf
- Any physician may request an expedited reconsideration on behalf of the enrollee

Part C ODAG-Reminders
Denial of OON Care after Referral

Key Audit Finding(s)/Compliance Issue(s):

- Inappropriate denial of Medicare-covered items and services provided by a non-contract provider as a result of a contract provider's referral

Part C ODAG-Reminders
Denial of OON Care after Referral (cont.)

Program Requirement(s):

- Plans must adhere to latest Medicare coverage criteria
- If an enrollee receives an item or service from a non-contracted provider on the basis of a referral to that provider for that item or service from a contracted provider, the enrollee cannot be held liable beyond applicable plan cost sharing for those services

References

Additional information on the topics discussed in this session can be found here:

- Part C
  - 42 CFR Part 422, Subpart M
  - Medicare Managed Care Manual, Chapter 13 “Medicare Managed Care Beneficiary Grievances, Organization Determinations and Appeals Applicable to Medicare Advantage Plans, Cost Plans and Health Care Prepayment Plans (HCPPs)”
- Part D
  - 42 CFR Part 423, Subpart M
  - Medicare Prescription Drug Benefit Manual, Chapter 18 “Part D Enrollee Grievances, Coverage Determinations and Appeals”

Questions?

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