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DATE: November 16, 2010

TO: All Part D Plan Sponsors

FROM: Michael Crochunis
Acting Director, Medicare Enrollment & Appeals Group

SUBJECT: Reminders Related to Timely Adjudication of Coverage Determinations and Appeals and a Notice of Change to the Part D QIC Filing Locations

The intent of this memorandum is to remind Part D plan sponsors of requirements related to timely processing of coverage determination (including exceptions) requests to ensure enrollees have access to medically necessary prescription drugs at the beginning of the 2011 plan year.

Timely Adjudication of Coverage Determination Requests

It is critical for Part D plan sponsors to have sufficient staff resources in place prior to the beginning of the 2011 plan year to ensure that coverage determination requests are processed timely and that enrollees (and prescribers, as appropriate) are promptly notified of decisions. This is particularly important if the plan sponsor's 2011 formulary includes significant changes from the 2010 plan year. Each Part D plan sponsor should conduct a review of its decision making processes, internal controls, and staffing levels and make any necessary adjustments to ensure that sufficient levels of well-trained staff are in place to process requests for the start of the 2011 plan year.

Part D plan sponsors must notify enrollees of coverage determinations as expeditiously as the enrollee's health requires, but no later than 24 hours for an expedited request and 72 hours for a standard request. For coverage determinations that do not involve an exception request, the adjudication timeframe begins when the request is received. For exception requests, the adjudication timeframe begins when the prescriber's supporting statement is received. If an enrollee is attempting to satisfy a prior authorization (PA) or other utilization management (UM) requirement, the adjudication timeframe begins when the request is received by the plan. In contrast, if an enrollee is seeking an exception to a UM tool, the adjudication timeframe begins when the plan receives the prescriber's statement in support of the exception request. Plan sponsors should have processes and staff in place to ensure that any clinical information needed to make a coverage determination decision is promptly solicited from the enrollee's prescriber.

Timely Autoforwarding of Cases to the Part D Qualified Independent Contractor (QIC)

If a Part D plan sponsor fails to notify an enrollee of a coverage determination or redetermination (appeal) within the required adjudication timeframe, the failure constitutes an adverse decision and the plan must forward the enrollee's request to the Part D QIC, Maximus, within 24 hours of the expiration of the adjudication time frame. Plan sponsors must also notify the enrollee within 24 hours that the case has been forwarded to the Part D QIC for review. Guidance on when a Part D sponsor must auto-forward a coverage determination can be found in Sections 40.4 and 50.6 of Chapter 18 of the *Medicare Prescription Drug Benefit Manual*. Guidance related to redeterminations can be found in Section 70 of the *Manual*. Appendix 6 of Chapter 18 of the *Manual* is a model notice plans may use to notify an enrollee that his/her case has been forwarded to the Part D QIC for review.

Part D plan sponsors must send complete and accurate case files to the Part D QIC. The Part D QIC's *Reconsideration Procedures Manual* contains specific instructions on case file submission. The current version of the *Reconsideration Procedures Manual*, version 5.2, (revised November 2010) and relevant forms, including the Case File Transmittal Forms (version 4.0 for Part D benefit appeals and version 3.0 for Late Enrollment Penalty appeals) can be found at www.MedicarePartDAppeals.com.

Please refer to Section 5 of the Part D QIC's *Reconsideration Procedures Manual* for details on the preparation and submission of case files. A Case File Transmittal Form must be completed for each case. It is particularly important that the case file include accurate prescriber information and complete information about the drug in dispute (including strength and quantity). Plan sponsors are strongly encouraged to include a complete plan formulary and evidence of coverage (EOC) on a CD in PDF format as part of the case file. The CD must be properly labeled with the plan name and contract number, formulary ID, enrollee name and HICN. The CD should only include the plan documents that are applicable to the case being sent for adjudication. Plan sponsors must not mail, fax, or e-mail complete copies of the EOC and/or formulary to the Part D QIC.

If a plan sponsor expects to autoforward more than 20 cases to the Part D QIC in a week, the plan should notify the Part D QIC's plan liaison, Suzan Elzey at suzanelzey@maximus.com or by telephone at 585-598-4424. Depending on the volume of cases being autoforwarded and any unique circumstances, the plan sponsor may be asked to prepare an accompanying spreadsheet with key information to assist in the efficient processing of the cases.

The number of cases autoforwarded to Maximus remains significant (>30%), raising the concern by CMS that some sponsors may be relying on the autoforward process as a substitute for devoting their own resources to conducting timely coverage determinations or redeterminations. CMS reminds all sponsors that we expect the autoforwarding process to be invoked on an occasional basis, and not used as a mechanism through which Maximus takes on work for which the sponsors are responsible.

Compliance Failures

Part D sponsors must comply fully with all requirements related to coverage determinations and appeals. Compliance with these requirements is particularly important as a Part D plan sponsor's failure to timely adjudicate coverage determination and redetermination requests and, when applicable, to autoforward cases timely to the Part D QIC may result in denying enrollees prompt access to medically necessary covered prescription drugs. Therefore, Part D sponsors that fail to comply with coverage determination and appeals requirements may be subject to compliance or contract enforcement actions.

Important Notice Related to Part D QIC Filing Locations

MAXIMUS has consolidated its operations and is processing all Drug Benefit and LEP appeals at its Fairport, NY site. Appeals will no longer be processed at the King of Prussia, PA site.

Part D plan sponsors are reminded that their appeals processes and forms must reflect the following Part D QIC case filing locations:

Addresses and contact information for PART D PLANS:

Part D Drug Benefit reconsiderations should be sent to the following filing location:

MAXIMUS Federal Services
Medicare Part D QIC
860 Cross Keys Office Park
Fairport, NY 14450
Fax number: (585) 425-5301
Customer Service: (585) 425-5300

Part D Late Enrollment Penalty (LEP) reconsiderations should be sent to the following filing location:

MAXIMUS Federal Services
Medicare Part D QIC
P.O. Box 991
Victor, NY 14564-0991
Fax number: (585) 869-3330
Customer Service: (585) 425-5300

In addition, where applicable, plan forms should be updated to reflect the following contact information for APPELLANTS:

Drug Benefit Reconsiderations:

Fax numbers: (585) 425-5390

Toll free fax: (866) 825-9507

Customer Service: 585-425-5300

Toll Free Customer Service: 877-456-5302

Late Enrollment Penalty Reconsiderations:

Fax numbers: (585) 869-3320

Toll free fax: (866) 589-5241

Customer Service: 585-425-5300

Toll Free Customer Service: 877-456-5302

Questions regarding the coverage determination and appeals content of this memorandum should be directed to PartD_Appeals@cms.hhs.gov.