

CENTER FOR MEDICARE

TO: All Part D Plan Sponsors and Medicare Hospice Providers

FROM: Tracey McCutcheon, MHSA, MBA, Acting Director
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SUBJECT: Part D Payment for Drugs for Beneficiaries Enrolled in Hospice—Final 2014
Guidance

DATE: March 10, 2014

On December 6, 2013, CMS issued a memorandum seeking to clarify the criteria for determining payment responsibility under the Part A hospice benefit and Part D for drugs for hospice beneficiaries. Based on these clarifications we suggested revised expectations for Part D sponsors to prevent duplicate payments for drugs covered under the hospice benefit or waived through the beneficiary's hospice election. We issued that guidance for industry review and comment. We thank all who took the time to respond for your thoughtful comments in response to our request.

We recognize there are many outstanding questions and agree that rulemaking is required to resolve most of those issues. In the meantime, we have addressed many of your comments in revising the following Part D guidance for 2014. As we undertake future rulemaking, we will take all commenter submissions into consideration.

CMS subject matter experts will be available on the April 9, 2014 Part C&D User Call to answer any questions from Part D sponsors related to this guidance. Additionally, questions can also be submitted to PARTDPOLICY@cms.hhs.gov. When submitting questions to this mailbox related to this guidance, please include "Hospice" in the subject line.

2014 Guidance for Part D Sponsors

Determination of Payment Responsibility for Drugs for Hospice Beneficiaries

As specified in section 1861(dd) of the Social Security Act and in Federal regulations at Part 418, the hospice is responsible for covering all drugs or biologicals for the palliation and management of the terminal and related conditions. Drugs and biologics covered under the Medicare Part A per-diem payment to a hospice program, therefore, are excluded from coverage under Part D. A number of commenters on the December 6 guidance recommended that CMS establish a transition period during which time drugs for a beneficiary who had elected hospice

would be covered under Part D, thereby permitting the hospice provider to transition the beneficiary to the hospice benefit and eliminating the need for Part D sponsor to retrospectively recover amounts paid under Part D prior to the sponsor's receipt of notice of the hospice election. While we appreciate the good intent and practicality of this approach, unfortunately we do not have the flexibility to permit Part D to pay for drugs that are covered under the Part A hospice per diem even during a limited transition period.

Drugs Covered under the Hospice Benefit

The hospice plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. As such, there may be some medications that were used prior to the hospice election that will continue as part of the hospice plan of care, and would be covered under the Medicare hospice benefit, if those drugs are necessary for the palliation and management of the terminal illness and related conditions.

Drugs That Are a Beneficiary Liability

There may also be some drugs that were for the treatment of the terminal illness and/or related conditions prior to the hospice election that will be discontinued upon hospice election, as it has been determined by the hospice interdisciplinary group, after discussions with the hospice patient and family, that those medications may no longer be effective in the intended treatment, and/or may be causing additional negative symptoms in the individual. These medications would not be covered under the Medicare hospice benefit, as they would not be reasonable and necessary for the palliation of pain and/or symptom management. If a beneficiary still chooses to have these medications filled through his or her pharmacy, the costs of these medications would then become a beneficiary liability for payment and not covered by Part D. These medications would not be covered by Part D because their further coverage is prohibited under Medicare.

Similarly, if a beneficiary requests a drug for his or her terminal illness or related conditions that is not on the hospice formulary and the beneficiary refuses to try a formulary equivalent first; or the drug is determined by the hospice provider to be unreasonable or unnecessary for the palliation of pain and/or symptom management, the beneficiary may opt to assume financial responsibility for the drug. However, no payment for the drug will be available under Part D.

When a drug is determined by the hospice provider to be the beneficiary's responsibility, Part D has no payment responsibility and payment coordination is not an issue. In those situations involving retrospective payment recovery, as discussed in the payment recovery section below, the sponsor should issue a recovery notice to the beneficiary.

Drugs Covered under Part D for a Beneficiary Who Has Elected Hospice

For prescription drugs to be covered under Part D when the enrollee has elected hospice, the drug must be for treatment of a condition that is completely unrelated to the terminal illness or related conditions; in other words, the drug is unrelated to the terminal prognosis of the individual. We expect drugs covered under Part D for hospice beneficiaries will be unusual and exceptional circumstances. **Therefore, the sponsor should place beneficiary-level prior**

authorization (PA) requirements on all drugs for beneficiaries who have elected hospice to determine whether the drugs are coverable under Part D. Because these PAs are necessary to establish whether the drug may be covered under Part D at all, a Part D enrollee's transition benefit has no impact on applying these edits.

Prospective Determinations of Payment Responsibility

Hospice-Provider-Initiated PAs

A number of hospice organizations suggested that hospice providers be permitted to initiate the PA process prior to the submission of a claim under Part D. We appreciate these suggestions and agree that this approach would go far to avoid any issues associated with data lags or the workload associated with fulfilling PAs. Initiating communication prior to a claim submission, such as at hospice election, will provide early notice of the election to the sponsor and limit retrospective recoveries. In addition to reporting the hospice election, the hospice provider could report election revocations or terminations and identify any drugs determined to be coverable under Part D and provide an explanation of why the drugs are unrelated to the terminal illness or related conditions. When hospice providers provide this documentation, sponsors should accept it and use it to satisfy the PA requirements. This is comparable to the process for best available evidence for low-income cost-sharing, and sponsors may use this information until the official notice is received from CMS. Providing this information at the time of the hospice election will facilitate the most timely access to drugs unrelated to a beneficiary's terminal illness or related conditions.

Hospice providers can proactively identify a beneficiary's Part D plan through the hospice pharmacy. Hospice pharmacies can identify a beneficiary's Part D plan by submitting a standard electronic eligibility (E1) query to the CMS Transaction Facilitator. The query response identifies the plan sponsor and provides the sponsor's online billing information, as well as the pharmacy help desk telephone number. The hospice provider can initiate communication or fulfill a PA through the sponsor's 24-hour pharmacy help desk.

Concurrent Determinations of Payment Responsibility

Prior Authorization Process

For 2014, sponsors should use the existing standard PA process (see process diagram in Attachment 1). As depicted in the diagram, the process begins when a Part D sponsor receives a pharmacy claim for a beneficiary who has elected hospice and rejects the claim with the following National Council for Prescription Drug Programs (NCPDP)-approved reject coding:

Code	Description
A3	This Product May Be Covered Under Hospice – Medicare A
75	Prior Authorization Required
569	Provide Notice: Medicare Prescription Drug Coverage and Your

Rights

In addition to the reject coding, sponsors should use point-of-sale messaging stating: Hospice Provider- Request Prior Authorization for Part D Drug Unrelated to the Terminal Illness or Related Conditions, and including the 24-hour pharmacy help desk phone number to call with questions.

When the pharmacy receives the claims reject coding with the associated messaging, the pharmacy contacts the beneficiary or prescriber to determine if the hospice provider should cover the drug. If the answer is yes, the pharmacy submits the claim to the hospice provider identified by the beneficiary or prescriber. If the answer is no, or neither the beneficiary nor prescriber know whether hospice provider should cover the drug, the pharmacy will provide the standardized pharmacy notice (i.e., Prescription Drug Coverage and Your Rights - Form CMS-10147) to the beneficiary and may direct the beneficiary and/or the prescriber to contact the Part D sponsor. As noted above, because of the recommended electronic claims messaging, the pharmacy will generally be able to provide the sponsor's help desk phone number. The beneficiary, the beneficiary's appointed representative, or the prescriber must contact the sponsor to initiate the PA fulfillment process. This contact is a request for a coverage determination and the sponsor must comply with the coverage determination timeframes and notice requirements.

The standardized pharmacy notice instructs the enrollee on how to contact his or her plan and explains an enrollee's right to request a coverage determination and receive a detailed written decision from the Part D plan sponsor regarding his or her Part D prescription drug benefits. Plan sponsors must arrange with their network pharmacies (including mail-order and specialty pharmacies) to distribute the notice. The pharmacy notice must be provided to the enrollee if the pharmacy receives a transaction response indicating the claim is not covered by Part D and the designated NCPDP response code is returned. The form and the form's instructions can be accessed on the CMS Website at: <http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html>.

If the beneficiary, the beneficiary's appointed representative, or the prescriber contacts the Part D sponsor to request a coverage determination, a number of scenarios may occur:

- The sponsor contacts the prescriber to complete the PA. The prescriber may provide a verbal explanation to the sponsor regarding why the drug is unrelated to the terminal illness or related conditions or complete the PA form and submit it to the sponsor via fax or mail.
- In some cases, such as when the prescriber is unaffiliated with the hospice provider and unable or unwilling to coordinate with the hospice provider to provide the required explanation for the PA, the sponsor may contact the hospice for the explanation as to why the drug is unrelated to the terminal illness or related conditions, but we do not necessarily expect the sponsor to be responsible for ensuring the PA is fulfilled. In these instances, the hospice provider can provide a verbal explanation to the sponsor regarding why the drug is unrelated to the terminal illness or related conditions or complete the PA form with the explanation and submit it to the sponsor. We believe that these instances are most likely to occur when the prescriber is unaffiliated with the hospice provider and

may require that the hospice provider contact either the prescriber or the Part D sponsor in order to explain why the drug is unrelated to the terminal illness or related conditions.

- To ensure care coordination, we believe prescribers who are unaffiliated with the hospice provider, in addition to providing the explanation regarding why the drug is unrelated to the terminal illness or related conditions, should also attest that they have coordinated with the hospice provider and the hospice provider confirmed the unrelatedness of the drug.
- The sponsor contacts the hospice provider to provide the required explanation for the PA and is informed that, although the drug is related to the terminal illness or related conditions, it has been determined to be a beneficiary liability.

Upon receiving and accepting the verbal explanation or the completed PA form, the sponsor instructs the pharmacy on how to override the edit and notifies the beneficiary. If the prescriber initiated the PA, the prescriber also receives notice from the sponsor. If the sponsor has determined that the prescriber is not affiliated with the hospice provider, the sponsor may also fax an informational copy of the PA to the hospice provider.

As previously noted, Part D coverage of a drug depends on whether the drug is covered under the hospice benefit. As a result, if the hospice provider or the prescriber does not respond or refuses to provide the required explanation regarding why the drug is unrelated to the terminal illness or related conditions, Part A coverage cannot be ruled out and the PA is unfulfilled; therefore, the sponsor must inform the beneficiary that the drug is not covered under Part D.

In addition to the beneficiary-level hospice PA for determining whether the drug is coverable under Part D, plan sponsor may have a utilization management (UM) edit on the drug that must also be satisfied. Although the beneficiary-level hospice PA is the threshold issue that must be considered when a coverage determination has been requested, we expect Part D plan sponsors to concurrently obtain and review the information necessary to promptly determine whether any applicable drug-specific UM requirement has been satisfied (or, alternatively, whether an exception to that UM requirement has been requested).

For purposes of the 2014 coordination of benefits processes outlined in this memo, we believe it is appropriate to apply the processing timeframes applicable to exception requests as described in section 30.2 of Chapter 18 of the *Medicare Prescription Drug Benefit Manual* to coverage determination requests that involve the beneficiary-level hospice PA. In other words, the applicable adjudication timeframe of 24 hours (for expedited requests) or 72 hours (for standard requests) begins when the explanation of unrelatedness to the terminal illness or related conditions is received from the hospice provider or prescriber. In accordance with existing guidance on processing timeframes for exception requests, a plan sponsor must not keep the request open indefinitely; while the adjudication timeframe may be tolled pending receipt of the necessary information, the start of the adjudication timeframe can only be tolled for a reasonable period of time based on the facts and circumstances of the case. Further, for coverage determination requests that also involve an exception to a drug-specific UM requirement, the adjudication timeframe can only be tolled once consistent with the above-stated expectation that the beneficiary-level hospice PA and the drug-specific UM requirement be considered concurrently.

When a hospice provider or prescriber provides information to document a drug is unrelated to the terminal illness or related conditions without a coverage determination having been requested (such as when the hospice initiates communication with the sponsor prior to a claim submission and provides the documentation necessary for the PA), a coverage determination request must be initiated by the beneficiary, the beneficiary's appointed representative or the prescriber and the applicable drug-specific UM requirements satisfied as part of the coverage determination process.

Many commenters recommended that we establish and require the use of a standard PA form. Although we cannot require a standard PA form in 2014, we have compiled a list (see Attachment 2) of the data elements that we would expect to request for oversight and that could also be used in a Part D hospice PA form (or documented by the sponsor when received verbally). We seek suggestions for revisions to the listed items that may be incorporated into a standard form at a later date. In the meantime, to keep the process as straightforward and consistent as possible among Part D sponsors, we strongly recommend that the form sponsors employ be limited to the information needed for a hospice PA and be used exclusively for that purpose.

, We expect that the hospice provider or prescriber will respond to outreach from the pharmacy, beneficiary or Part D sponsor as quickly as possible to provide the information necessary to satisfy the PA. Again, this is limited to an explanation regarding why the drug is unrelated to the terminal illness or related conditions and therefore not covered under hospice or is related to the terminal illness or related conditions and, therefore, is a responsibility of the hospice provider or beneficiary. However, if the prescriber is unaffiliated with the hospice provider, we believe for purposes of care coordination the prescriber should also attest that the hospice provider has confirmed the unrelatedness of the drug. We expect the sponsor to accept the PA explanation (and attestation, if applicable) either verbally or in writing and process the claim for payment under Part D.

Retrospective Determinations of Payment Responsibility

If the Part D sponsor has paid for drug claims prior to receiving notification of the beneficiary's hospice election, the sponsor must perform a subsequent review of claims paid within the hospice election period and should conduct outreach to the hospice provider or prescriber to make retrospective determinations of payment responsibility for the drugs. In order to determine whether the drug is for treatment of a condition unrelated to the terminal illness or related conditions, CMS expects the prescriber or hospice provider to coordinate with the plan sponsor regarding these claims and, as requested by the sponsor, provide the necessary written information explaining why either (1) the drug is unrelated to the terminal illness or related conditions or (2) is a beneficiary liability.

Part D Payment Recoveries from the Medicare Hospice or the Beneficiary

For 2014, with the implementation of PA requirements on all drugs for beneficiaries who have elected hospice, retrospective payment recoveries will only be necessary for claims paid on or

after the effective date of the hospice election and prior to the sponsor's receipt of notification. CMS Part D policy regarding payer-to-payer reconciliation in Chapter 14 of the Medicare Prescription Drug Benefit Manual section 50.14.4 addresses scenarios in which Part D sponsors must work with other payers who either pay when they should not have paid at all, or pay more than they should have, because they paid out of the correct payer order. We believe the inverse of this guidance also applies. That is, in scenarios in which Part D sponsors pay and should not have, because payments were the responsibility of other payers, the payers should work together to reconcile the payment issues.

This is applicable in scenarios involving drugs for beneficiaries who have elected hospice. In such scenarios, the other payer is the hospice provider, and CMS expects sponsors and hospice providers to work directly with each other to resolve payment responsibility and recover amounts paid. Therefore, upon receipt of notification of the hospice election, sponsors should review the beneficiary's claims to identify claims that should have been excluded from coverage under Part D. Sponsors should seek a retrospective determination of payment responsibility by contacting the prescriber or hospice provider for either an explanation of why the drug was unrelated to the terminal illness or related conditions or is a beneficiary liability, or a determination that the drug should have been covered under the hospice benefit.

In those scenarios in which the drug is determined to be a hospice liability, the parties should negotiate repayment. In the scenarios in which the beneficiary is liable, such as when the member has requested a non-formulary drug from the hospice and refused to try a formulary equivalent, or the drug was determined by the hospice provider to be unreasonable or unnecessary, but the beneficiary agreed to assume financial responsibility for it, the sponsor should send a recovery notice to the beneficiary.

Sponsors should implement processes to handle payment resolution directly with hospice providers and beneficiaries without requiring the pharmacy reverse and rebill the original claim in the retail setting. However, whenever the network pharmacy involved is also the hospice pharmacy, as is often the case with long-term care pharmacies, reverse and rebill may be the most appropriate approach. We received a couple of comments from Part D sponsors regarding the handling of PDE records in these situations. Sponsors should refer to the guidance in the July 3, 2013 memorandum entitled, "PDE Guidance for Post Point-of-Sale Claim Adjustments," for determining the appropriate course of action.

CMS Hospice Data and Data Flow

Hospice Election, Certification, and Benefit Periods

To receive hospice care, an individual (or an authorized representative) must elect the hospice benefit and must be certified by a physician as terminally ill. A hospice election continues until the beneficiary revokes the election, is discharged, or passes away. As noted previously, a NOE is completed by the hospice and filed with the Medicare contractor, to transmit the data to CMS' Common Working File (CWF) in electronic format. The data are reported by the CWF to other CMS systems (see Attachment 3 for a chart of the data flow). An election is comprised of one or more benefit periods. The initial certification and benefit period is for 90 days. After the initial

period, subsequent periods consist of another 90-day period and an unlimited number of 60-day periods.

Hospice Information Reported on the TRR

Hospice election information is sent to sponsors on the DTRR. As specified in the Plan Communications User Guide, the DTRR includes a hospice indicator, a hospice start date and a hospice termination date (see Attachment 4 for the hospice-related fields). Hospice data are reported on the DTRR at the time of the beneficiary's enrollment in a Part D plan, or hospice election if that election is made later. Updated data are reported when the hospice start dates change to reflect a new benefit period or a termination date is added due to death, discharge, or revocation of the election by the beneficiary.

Only one hospice benefit period can be reported on the DTRR. Thus, the hospice start date will be the date the current benefit period started. When the current benefit period ends, a new start date will be reported reflecting the start date of the new benefit period. Termination dates are reported on the DTRR only when the hospice benefit has terminated due to death, discharge, or revocation of the beneficiary's election. Thus, if no hospice termination date is reported on the DTRR, the new start date is the beginning of a new benefit period. Therefore, a new start date should not be viewed as an indication that the beneficiary revoked his/her hospice election and then re-elected the benefit, or was discharged and re-elected, creating an entirely new election. When a beneficiary revokes a hospice election or is discharged, the effective date of the revocation or discharge will be reported as the hospice termination date on the DTRR. If the beneficiary revoked the election, a hospice revocation indicator will be included in the MARx system. Please note that when a beneficiary revokes his/her hospice election or is discharged from hospice care, the beneficiary immediately resumes Medicare coverage of the benefits waived when hospice care was elected.

Since only a single hospice benefit period can be reported on the DTRR, sponsors will need to store the hospice data in their systems so historical data are available when needed for claims adjudication and adjustments. Sponsors can also access additional hospice data via MARx User Interface, including prior benefit period start and end dates and the hospice revocation indicator (see Attachment 5 for a sample of the MARx hospice data screen).

We received a number of comments requesting that we expand the DTRR to include fields for the name, address and phone number of the hospice. Due to the lack of resources for systems enhancements at this time, we cannot promise any changes to CMS' data reporting. We will, however, continue to explore approaches for expediting the reporting of the hospice data to make it more timely, thereby reducing the need for retroactive claims adjustments and deletions of prescription drug event (PDE) records.

Hospice Information Available through the Health Plan Management System (HPMS) and on the cms.gov Website

Sponsors may use the MARx User Interface or information supplied by the pharmacy, prescriber or beneficiary to identify the hospice and, once hospice is identified, the hospice contact information will be available to sponsors through HPMS prior to the effective date of the

guidance. The hospice information from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) also will be accessible on the CMS Website on the Hospice Center Webpage located at <http://www.cms.gov/Center/Provider-Type/Hospice-Center.html> in the Spotlight section; the list will be posted as soon as possible, but no later than the effective date of the guidance.

According to Medicare Enrollment policy, providers are required to submit any changes to their enrollment information in PECOS in a timely manner. Therefore, we expect hospice providers will ensure that their information is current and complete and will review the list and submit any required changes electronically to PECOS. The system is accessible via the CMS Website at: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>.

CMS' Independent Reviewer

Many commenters on the December 6th memorandum indicated the establishment of an independent reviewer process would require rulemaking and requested we work with stakeholders to establish standards and criteria for the reviewer to use in making coverage determinations, reviewer qualifications and timeframes for each phase of the process. We agree and will consider the process for future rulemaking.

Thus, there will be no process for dispute resolution for 2014. Instead, CMS expects:

- The hospice provider and Part D sponsor to coordinate their benefits;
- The hospice provider or the prescriber to promptly provide verbal communication or written documentation from the hospice provider or prescriber in order to satisfy the beneficiary-level hospice PA. That is, information explaining why the drug is unrelated to the terminal illness or related conditions, or is related to the terminal illness or related conditions and, therefore, is a responsibility of the hospice provider or beneficiary;
- The Part D sponsor to accept and maintain the documentation that the drug is unrelated to the terminal illness or related conditions and is, therefore, reimbursable under Part D and process the claim; and
- The sponsor and hospice to negotiate the retrospective recovery of the amounts paid, if the sponsor has paid for drugs after the effective date of the hospice election, but prior to receipt of notification from CMS.

Effective Date of Clarified Part D Guidance

The effective date of this policy clarification will be May 1, 2014 and will be applied prospectively. We recognize that, prior to this date, Part D guidance was ambiguous and there were no objective criteria for Part D sponsors to apply in making Part D versus Part A coverage and payment determinations.

Part D Star Ratings

Several commenters requested that hospice-related complaints be excluded from the sponsors' star rating. We would expect that most complaints will be about the hospice and sponsors should

report these to CMS Regional Office via the usual process and such complaints would not be attributable to the plan. However, sponsors should work to ensure that PAs are acted upon quickly once the prescriber or hospice responds.

Implications for Beneficiaries

Beneficiary Fee-for-Service Claims and Appeals

Sometimes a beneficiary requests a certain medication that a hospice can't or won't provide because it's not reasonable and necessary for the palliation and management of the terminal illness and related conditions. The cost of such a medication, which is not reasonable and necessary for the management of the terminal illness or related conditions, would be a beneficiary liability. If the hospice does not provide the medication, the hospice is not obligated to provide any notice of non-coverage (including the Advance Beneficiary Notice of Non-coverage or ABN). If the hospice provides the medication even though it is not reasonable and necessary, it must issue an ABN in order to charge the beneficiary for the medication. Regardless of whether or not the hospice furnishes the drug, if the beneficiary feels that the Medicare hospice should cover the cost of the drug, the beneficiary may submit a claim for the medication directly to Medicare on Form CMS-1490S. If the claim is denied, the beneficiary may file an appeal of that determination under the appeals process set forth in part 405, subpart I.

If the beneficiary desires to continue taking drugs that are not covered by Medicare Part A or Part D, then the hospice must fully inform the beneficiary of his or her financial liability. Beneficiaries who disagree with such determinations may continue raising these issues through the Medicare fee-for-service appeals process if the determination relates to Part A or B coverage and the Part D appeals process if the determination relates to Part D coverage. Beneficiaries may also submit quality of care complaints to a Quality Improvement Organization when the beneficiary prefers a non-formulary drug because, for example, it's believed to be more efficacious than the formulary drug prescribed by the hospice.

Part D Transition for Changes in Level of Care

Existing transition guidance in Chapter 6 of the Medicare Prescription Drug Benefit Manual §30.4.7 discusses level of care changes and transition. The guidance states that circumstances exist in which unplanned transitions for current enrollees could arise and in which prescribed drug regimens may not be on sponsor formularies. These level of care changes involve a beneficiary changing from one treatment setting to another, and include beneficiaries who revoke hospice to revert to standard Medicare benefits.

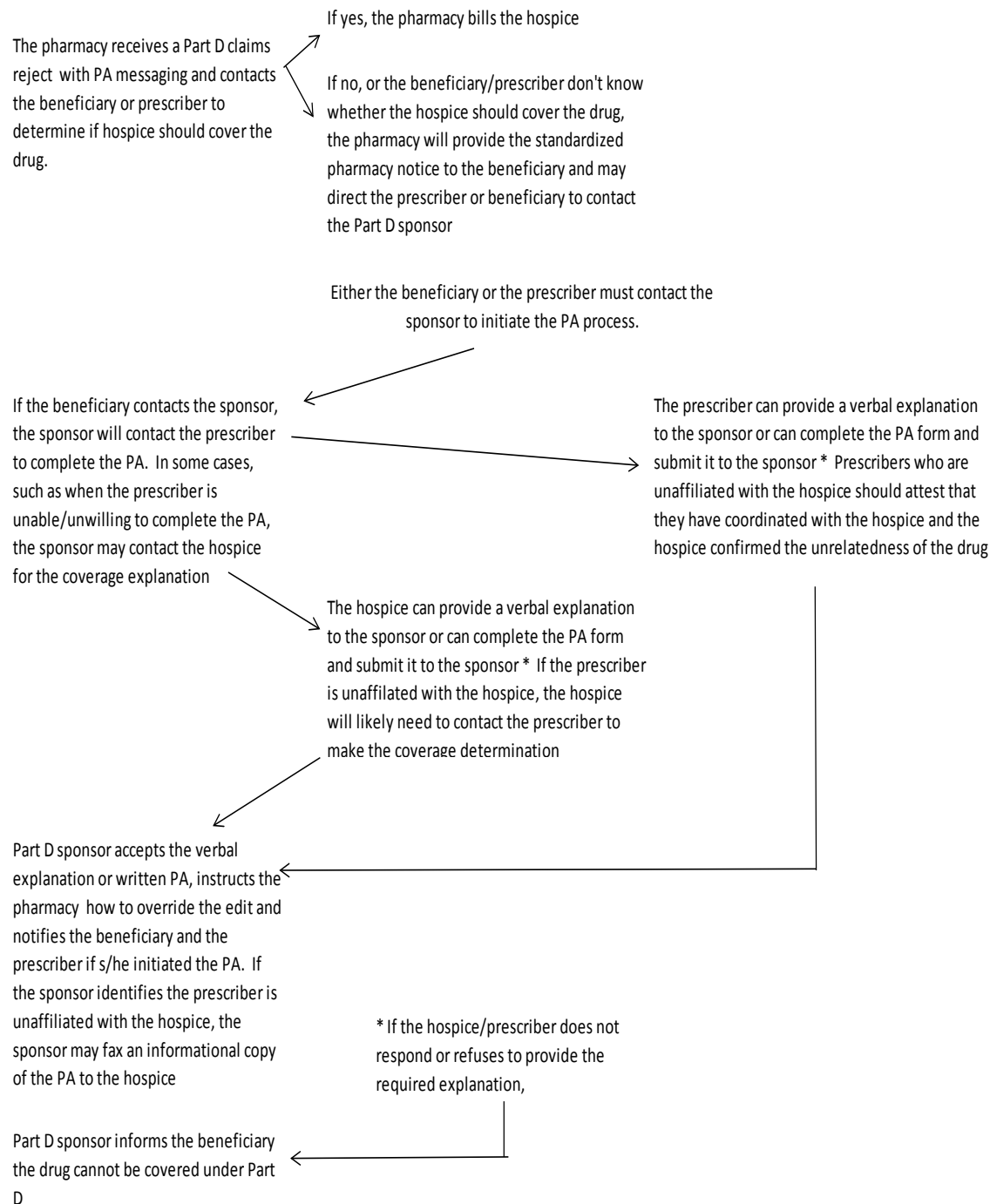
For these unplanned transitions, beneficiaries and providers must avail themselves of sponsor exceptions and appeals processes. CMS has streamlined the grievance, coverage determination, and appeals process requirements in order to ensure that beneficiaries receive quick determinations regarding the medications they need. In all cases, CMS makes it clear that a Part D sponsor is required to make coverage determinations and redeterminations as expeditiously as the enrollee's health condition requires.

Other Beneficiary Issues

Several commenters inquired about a Part D special enrollment period (SEP) for hospice beneficiaries and whether hospice was considered creditable coverage. We will consider the SEP and creditable coverage issues for future sub-regulatory guidance or rulemaking, as necessary.

Several others indicated that CMS' beneficiary communications should describe the interaction between hospice and Part D and beneficiary appeals rights under Part D following a hospice coverage determination. We agree with these commenters and will be working with appropriate CMS staff in reviewing our beneficiary materials pertaining to hospice and Part D coverage and revising those materials as required.

Attachment 1- Prior Authorization based on Part D Claim Reject at Point-of-Sale



Note: This diagram is intended to be an approximate rendering of the overall process and may not address every scenario.

Attachment 2- Medicare Part D Hospice Prior Authorization Information

Part D Sponsor/PBM Information for faxing/mailing

Name

Address

Fax #

Phone #

Today's Date

PATIENT and INSURANCE INFORMATION

Patient Name

DOB

Patient Phone#

Insurance ID Number

PRESCRIBER INFORMATION

Prescribing Physician's Name

Physician NPI#

Clinic Name:

Clinic Address

City, State, Zip

Clinic Contact Person's Name

Clinic Phone #

Clinic Secure Fax #

PRESCRIPTION INFORMATION

Medication Requested

Strength

Dosing Schedule

Quantity per Month

PRIOR AUTHORIZATION INFORMATION

1. Is the patient currently enrolled in Hospice?

If No, date of disenrollment

Hospice name and contact information:

Name

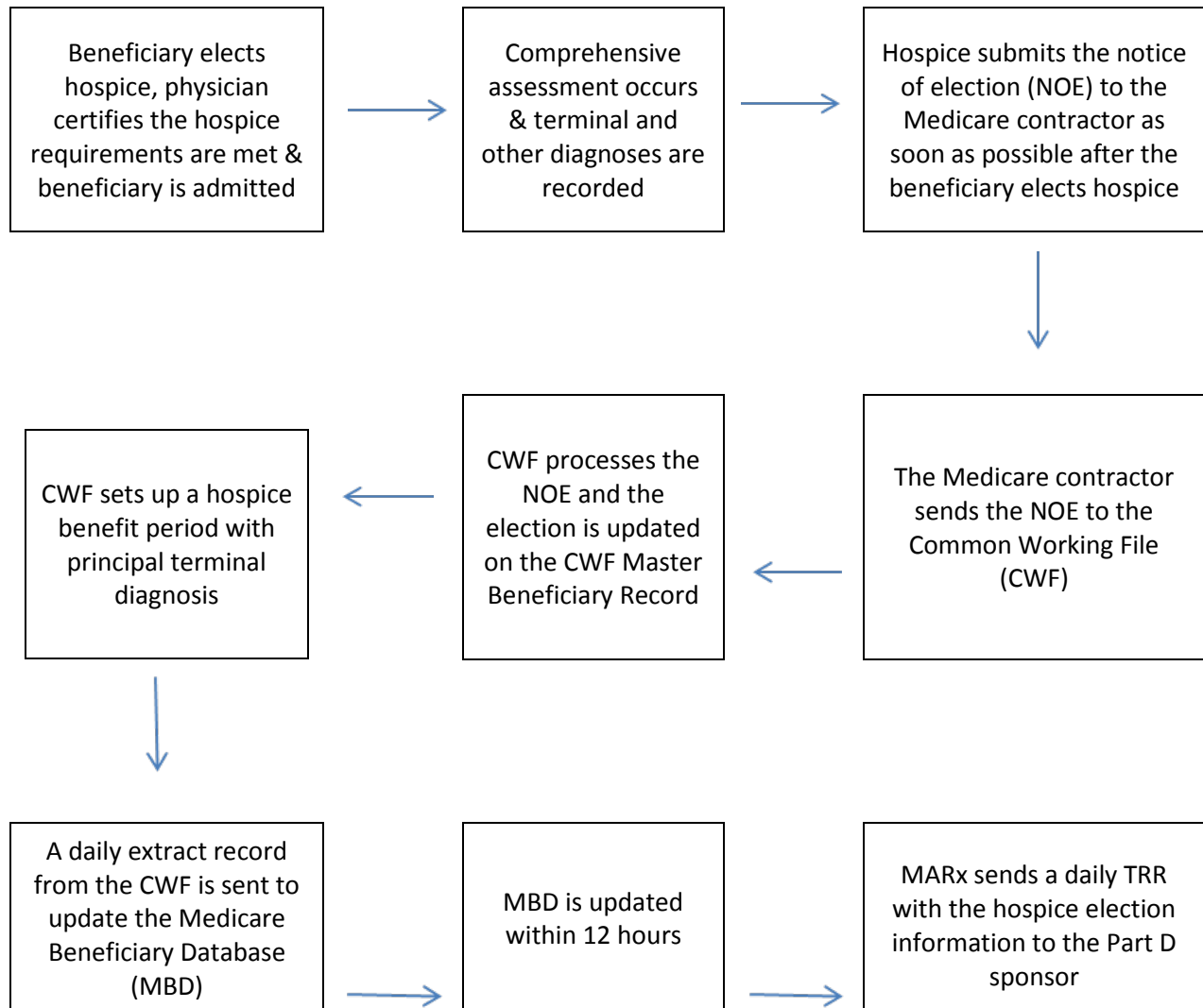
Phone #

Secure Fax #

2. Is the medication related to the terminal illness or related conditions and covered under the hospice benefit?

3. If no, is the medication not covered by Hospice because:
 - a. It is being used for a condition unrelated to the terminal illness or related conditions? If so, please provide an explanation of why the condition being treated is unrelated to the terminal illness or related conditions and therefore is not covered under hospice benefit and may be covered under Medicare Part D.
 - b. It is being used for a condition related to the terminal illness or related conditions, but the medication is not included on the hospice formulary, is not medically necessary or is waived through the hospice election? Medicare Part D will not cover this medication.
4. If the prescriber of the medication is unaffiliated with the hospice provider, has the hospice provider confirmed that the medication is unrelated to the terminal illness or related conditions?

Attachment 3- Hospice Data Flow



Attachment 4- Daily Transaction Reply Report (DTRR) (excerpted from PCUG)

F.14.1 DTRR Data File Detailed Record Layout

Item	Field	Size	Position	Description
12	Hospice Indicator	1	54	'1' = Hospice; '0' = No Hospice; Space = not applicable.
15	Transaction Reply Code (TRC)	3	57-59	TRC, see TRC list on page I-2 for values
18	Effective Date	8	63-70	YYYYMMDD Format; Effective date is present for all TRCs.
24	Positions 85 – 96 are dependent upon the TRC value. There are spaces for all codes except where indicated below.	8	85-92	This field value depends on the TRC that is returned on the reply. See the TRC-related values below:
	e. Hospice Start Date	8	85-92	YYYYMMDD Format; Present only when TRC is 71
	f. Hospice End Date	8	85-92	YYYYMMDD Format; Present only when TRC is 72

Table I-2: Transaction Reply Codes

Code	Type	Title	Short Definition	Definition
071	M	Hospice Status Set	HOSPICE ON	This TRC is returned on a reply with Transaction Type 01 and occasionally with Transaction Type 51, and Transaction Type 61. When returned with Transaction Type 01, the TRC is in response to a change in beneficiary Hospice status. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. In the case of Transaction Type 01, a notification has been received that this beneficiary is in Hospice status. The date on which Hospice Status became effective is reported in DTRR data file fields 18 and 24. The effective date for Hospice Status is not restricted to the first or last day of the month. It may be any day of the month. When this TRC is returned with Transaction Type 61 the TRC is in response to a retroactive enrollment and is identifying the fact that an enrollment end date has been established due to the beneficiary's hospice status. The enrollment start date is in DTRR data file field 18 and the enrollment end date is in field 24. In this circumstance it is accompanied by TRC 018, Automatic Disenrollment, as well.
072	M	Hospice Status Terminated	HOSPICE OFF	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. A notification has been received that this beneficiary's Hospice Status has been terminated. The end date for the Hospice Status is reported in DTRR data file fields 18 and 24. The date for termination of Hospice Status is not restricted to the first or last day of the month. It may be any day of the month.

Claim #: [REDACTED] **Name:** [REDACTED] **DOB:** [REDACTED]

Address: [REDACTED] **ACTIVE**

Status View (M205)

User: OF18 Role: CMS CENTRAL OFFICE USER Date: 10/22/2013

Payments | Adjustments | Premiums | SSA - RRB | PW Paid/Collected | History | Transactions | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Shapellet | Enrollment | Status

Age: 91 Sex: FEMALE
State: OH (6) County: SUMMIT (780)
Status: OH (6) County: SUMMIT (780)

Close Update Print Photo Change User View

Status 1.1(of 1)(Click on Status to view details)

Contract	PBP	Segment	Enrollment Period	Status Period	Status
			Start Date	End Date	
[REDACTED]	801	000	01/01/2006	12/22/2012	Hospice

Hospice Details

Start Date	End Date	Provider Number	Revocation Code	Record Add Timestamp
08/19/2013	10/17/2013	[REDACTED]	0	09/07/2013 11:02:59 AM
06/20/2013	08/18/2013		0	07/09/2013 08:15:24 AM
03/22/2013	06/19/2013		0	04/14/2013 03:20:05 AM
12/22/2012	03/21/2013		0	01/15/2013 05:42:59 PM