PART D
Advisor

November 2009
Issue 1

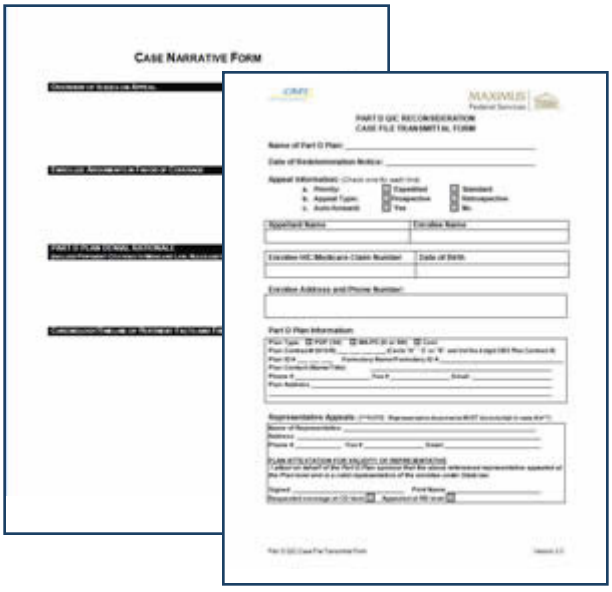
MAXIMUS Federal Services

Case File Submission Forms Ensure Information is Accurate & Complete

When MAXIMUS Federal Services receives a request for reconsideration review, for both drug and LEP appeals, we fax a Reconsideration Case File Request Form to the Part D Plan. This form is a formal request for the Part D Plan to provide a copy of the case file in proper form to the QIC. While the majority of Plans respond with complete information, occasionally we see incomplete forms or information submitted on unofficial or outdated forms. Ultimately, this results in additional calls to Plans and health care providers, incomplete data entered in the Medicare Appeals System, and additional review time.

To prevent these and other problems caused by missing information, Prescription Drug Plans (PDP) and Medicare Advantage Prescription Drug Plans (MA-PD) should respond to the case file request by preparing and submitting case files as documented in the MAXIMUS Part D QIC Reconsideration Procedures Manual, located on our website: www.medicarepartdappeals.com. This manual serves as a resource to Part D Plans in the processing of reconsiderations and related post-reconsideration activities for Part D appeals.

All Part D case file submissions should be accompanied by a Case File Transmittal Form and Case Narrative. These forms have been approved by CMS to assist the Part D QIC with appeal creation and data entry. They can be found on the Part D QIC website: www.medicarepartdappeals.com.



Case File Transmittal Form (CFTF) When properly completed, this form contains all of the pertinent information required by the QIC to start an appeal. It includes the Plan contract number, Plan ID number, formulary ID number and the Plan type. In addition, the form requires the Plan to provide information about the appeal at the Plan level of review. The Part D QIC will use this information to access the Plan's formulary in HPMS and to enter

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MAXIMUS Federal Services is pleased to provide you with this issue of the *Part D Advisor*, a newsletter for sharing information with the Medicare Part D Plans.

If you have questions, comments, or suggestions for future topics, please contact:

Suzan Elzey, Plan Liaison
Medicare Part D QIC
860 Cross Keys Office Park
Fairport, NY 14450
Ph. (585) 598-4424

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data into the Medicare Appeals System. It is imperative the fields on this form are complete and accurate.

Case Narrative When properly completed, this form provides an outline of the facts at issue on appeal. It allows the Plan to provide its denial rationale and a chronology of the appeal, or an explanation of why the decision-making timeframe was missed.

CMS Rule Changes Affecting Physicians and Other Prescribers

On January 12, 2009, CMS posted a new final rule in the Federal Register setting forth regulatory changes for Part D. This rule includes a new definition for "other prescriber," which encompasses health care professionals, other than physicians, with authority under State law or other applicable law to write prescriptions (e.g. nurse practitioners). Accordingly, "or other prescriber" was inserted after "prescribing physician" or "physician" throughout subpart M of part 423 in order to authorize these other prescribers to perform the same functions that prescribing physicians are allowed to perform with respect to the coverage determination and appeals processes. This means that as of March 13, 2009, when this final rule took effect, other prescribers are now permitted to provide supporting statements for exceptions requests.

Also effective March 13, 2009, physicians and other prescribers can now appeal on an enrollee's behalf without an Appointment of Representative document (AOR) at both the coverage determination and redetermination levels. As a result, for autoforwarded cases, the Part D QIC does not need representation documentation for appeals initiated by prescribers (the only caveat being that the prescriber must be authorized under applicable state law to write prescriptions).

To access the complete rule, go to: http://edocket.access.gpo.gov/2009/pdf/E9-148.pdf or http://edocket.access.gpo.gov/2009/E9-148.htm

New Location for Part D QIC Drug Appeal Submissions

Recently the Part D QIC's Victor office relocated to new office space located in Fairport, New York. *Effective immediately,* Plans should submit all drug appeal case files to our New York area office as provided below.

MAXIMUS Federal Services
Medicare Part D QIC
860 Cross Keys Park
Fairport, NY 14450

Fax: (585) 425-5301
(585) 425-5390
(585) 425-9401

If the volume of autoforwarded appeals exceeds 20 or more cases at one time, please notify Suzan Elzey, Plan Liaison, directly at phone number 585-598-4424.

Plans should continue to submit Late Enrollment Penalty case files to the King of Prussia, PA office for processing:

MAXIMUS Federal Services
Medicare Part D QIC
1040 First Avenue, Suite 200
King of Prussia, PA 19406

Part D QIC Fax Process Changes

Effective immediately, the Part D QIC will fax all drug appeal decision letters to Part D Plans. Plans will no longer receive drug appeal decision letters via the mail. Decision letters will be faxed to the contact listed on the Part D Case File Transmittal Form. If a Case File Transmittal Form has not been provided, the decision letter will be faxed to the primary Part D Contact that we have on file.

Auto-forwards and AORs: Don't Jump the Gun!

Typically, when a plan receives a standard request for coverage or payment of a Part D drug benefit, or a standard redetermination request, the Part D Plan must notify the enrollee (and the prescriber involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours or seven days, respectively, after the date and time the plan receives the request. A Part D Plan that approves a request to expedite a coverage determination or redetermination must make the determination and notify the enrollee and the prescriber involved, as appropriate, of its decision as expeditiously as the enrollee's health condition requires, but no later than 24 or 72 hours, respectively, after receiving the request. However, these timeframes do not commence if the requestor is a non-prescriber representative and the appropriate Appointment of Representative (AOR) documentation has not been submitted with the coverage or redetermination request. Accordingly, Part D Plans should not automatically forward these cases to the Part D QIC after the applicable timeframe has elapsed. (See Chapter 18, section 10.4.1, Appointed Representative Filing on Behalf of the Enrollee.)

> *. . .timeframes do not commence if the requestor is a non-prescriber representative and the appropriate Appointment of Representative (AOR) documentation has not been submitted with the coverage or redetermination request . . .*

IMPORTANT NOTE: There are two situations where the Part D Plan does not need to obtain Appointment of Representative documentation. If an enrollee is incapacitated or incompetent, and the appellant has submitted appropriate legal representation documentation (e.g. Power of Attorney), the Plan does not need to obtain separate AOR documentation. Likewise, as explained on page 2 of this newsletter, if the appellant is a prescriber, Appointment of Representative documentation is not required at the coverage determination or redetermination levels.

For those cases requiring an AOR, it is the Plan's obligation to make and document reasonable efforts to secure the necessary appointment forms by informing the enrollee and would-be representative that the request will not be considered until the appropriate documentation is provided. In the meantime, the Plan's decision timeframe can be viewed as being "tolled" or "paused" due to the lack of the requisite proof of representative authority. A plan's "reasonable efforts" to secure the forms depend on the circumstances. For example, if a request is expedited, contacting the enrollee and/or representative by mail to obtain the necessary appointment forms or notice may not be reasonable. However, if the enrollee and/or the party who submitted the request do not have a telephone, the Plan may determine that contacting the enrollee and/or the party by overnight delivery is reasonable.

If the Part D Plan has made the effort to obtain the appropriate forms but does not receive the form or statement within a reasonable time, the Plan should dismiss the request on the grounds that a valid request was not received. The Plan must send a written dismissal letter to the enrollee and the person asserting representative status. The dismissal letter should explain that the Plan will process the request if the enrollee or appointed representative resubmits the request with a properly executed Form CMS-1696 or other equivalent notice.

> *. . .If the Plan attempts to autoforward a case to the QIC and the respective timeframes for issuing a coverage determination or redetermination have not elapsed (as noted above), the QIC will remand the case back to the plan. . .*

The key point here is that the Part D Plan is not required to undertake a review until or unless valid representative forms are obtained. The Plan may choose to begin the review while continuing efforts to obtain a valid appointment of representative form. However, the timeframe for acting on a coverage determination or redetermination request does not commence until the properly executed appointment form is received. If the Plan attempts to autoforward a case to the QIC and the respective timeframes for issuing a coverage determination or redetermination have not elapsed (as noted above), the QIC will remand the case back to the plan. The basis for the remand is the timeframe for processing the request at the plan level has not elapsed.

FAQs Regarding Part D Appeals

Q. Why Does the Part D QIC Require an Evidence of Coverage?

Answer: The Evidence of Coverage (EOC) provides a detailed description of the member's covered benefits. This is a crucial document that the Part D QIC Appeals Team relies on to help with the decision-making process. As noted in the final 2010 Call Letter issued March 30, 2009, CMS strongly recommends that all Medicare health plans and Part D plan sponsors include complete copies of the relevant Evidence of Coverage (EOC) and/or formulary (Part D sponsors) with any case files sent to an independent review entity (IRE) for review.

For example: A member is enrolled in a plan with a supplemental benefit that covers several excluded drugs. The member requests coverage for Viagra; the Plan denies on the grounds that Viagra is an excluded drug under Social Security Act section 1927(d)(2). The member appeals and requests coverage based on the Plan's supplemental policy, which the plan states does not include Viagra.

In this instance the EOC enables the QIC to identify the supplemental drugs that the Plan does cover. Accordingly, the EOC must be provided to the Part D QIC as evidence to support the Plan's denial.

Q. How Does the Part D QIC Use HPMS?

Answer: HPMS, or the Health Plan Management System, is an information source for the Part D QIC. It contains Plan formularies and cost utilization tools employed by the plans, including quantity limit restrictions, prior authorization, and step therapy rules.

The Part D QIC uses HPMS to ascertain the formulary status of a medication and whether or not it is subject to any cost utilization restrictions. The Part D QIC relies on the information contained in HPMS when performing a reconsideration review. Sometimes the information contained in HPMS conflicts with the information provided by the Plan. For example, if the Plan's case file information indicates that a drug is on the Plan's formulary subject to prior authorization, but HPMS indicates no prior authorization, then the Part D QIC will rely on HPMS (unless there is evidence that HPMS is incorrect or has not been properly updated).

The Part D QIC also uses HPMS to access the Plan's Summary of Benefits. Normally, this feature of HPMS is used as a last resort when the Plan's Evidence of Coverage is unavailable.

Finally, HPMS is used to review memoranda issued by CMS. CMS frequently issues memoranda on a variety of policy concerns related to the Prescription Drug Benefit.

For additional information related to HPMS, the Plans should contact the HPMS Help Desk at 1-800-220-2028 or at hpms@cms.hhs.gov.

Q: Why is it Important for a Part D Plan to Distinguish Between a Coverage Determination and a Grievance?

If an enrollee has a complaint about his or her Part D Plan that does not involve coverage or payment for a drug covered by the Plan, he/she has the right to file a complaint with the Plan (called a "grievance"). A complaint should be filed within 60 days of the event that led to it. Examples of why an enrollee might file a complaint include, but are not limited to, the following allegations:

- Enrollee believes the Plan's customer service hours of operation should be different.
- Enrollee has to wait too long for a prescription.
- The Plan does not give enrollee a decision about a coverage determination or redetermination within the required time frame.
- Enrollee disagrees with the Plan's decision not to grant a request for an expedited coverage determination or redetermination.

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- The Plan did not provide the required notices.
- The Plan's notices do not follow Medicare rules.

Part D Plans must have established internal processes and procedures for identifying and distinguishing requests for coverage from complaints and grievances. In some cases, complaints may involve both grievances and coverage determinations. For example, an enrollee is prescribed Zithromax and told by her prescriber to start on it right away. The enrollee is told by the network pharmacy that it will take several hours to fill her prescription. The enrollee believes this is too long to wait and she obtains the medication more quickly out of network. The enrollee writes the Plan and requests reimbursement for her out-of-pocket expenses and also expresses her dissatisfaction with the length of time the network pharmacy told her it would take to fill her prescription. Her complaint contains both a request for payment (i.e., a request for a coverage determination) and a grievance about the timeliness of benefits.

The Part D QIC only handles appeals. It does not handle grievances or complaints. For matters concerning quality of care issues, including but not limited to prescription drug therapy, Part D Plans must cooperate with the Quality Improvement Organization (QIO) in resolving a complaint filed by an enrollee. A state list for respective QIOs is available on the Medicare Quality Improvement Community (MedQIC) website: www.qualitynet.org.

For further clarification and examples, please refer to Chapter 18, Section 20.2.

Part D QIC Correspondence and Protected Health Information

The 2009 Call Letter to Part D Plans, effective January 1, 2009, outlines a significant change to the Part D QIC's correspondence. To better protect enrollee health information, the Part D QIC now truncates all HICNs to include only the last 4 digits and suffix (xxx-xxx-1234A) on correspondence going to Medicare beneficiaries and representatives. Likewise, the enrollee's full name is no longer included on this correspondence. Instead, the only additional data points are the enrollee's first initial, last name and date of birth. This change serves to protect enrollee identifiable information should any QIC correspondence be misrouted. The Part D QIC had previously implemented this change for all of its outgoing correspondence; however, the Plans experienced difficulty in tracking enrollees with the limited identification data. Accordingly, the Part D QIC has taken measures to reinstate the use of the full HICN and enrollee name on correspondence going to Part D Plans, such as case file request forms, decisions letters and effectuation notices. Please note, the Part D QIC does need the enrollee's full HICN on correspondence received from Plans when submitting case files and autoforwarded cases, since the HICN is the sole identifier the Part D QIC uses to track its appeals.

QIC Tip: All communications to MAXIMUS Federal Services should include the Plan contract identification number—this is often omitted.

Communicating Changes to the QIC

Part D Plans are responsible for communicating all contact changes to the Part D QIC. This information includes the Plan's fax number, phone number, address and main point of contact for both drug and LEP appeals, respectively. With the inclusion of new Part D Plans each year, it is imperative that the QIC receives the Plan's preferred contact information. This information is logged into the QIC Organizations database and utilized for requesting case files and general communication. If contact information has changed, Plans must complete an updated Plan Contact Form, which is located on the Part D QIC website: www.medicarepartdappeals.com. Please fax the completed Plan Contact Form to Suzan Elzey at fax number 585-425-5301.

When the Part D QIC receives a written reconsideration request from an enrollee, it must request the case file as expeditiously as possible. In order to do this, the information the Plans provide on the Part D Plan Contact Information Forms must be accurate and current. Be sure to resubmit this form as soon as possible when any Plan contact information changes occur.

QIC Tip: *To ensure timely case file processing, the Part D Plan must include the enrollee's Medicare Claim number. The Medicare Claim Number (MCN) is also referred to as the Health Insurance Claim (HIC) Number. Medicare issues these numbers to all of its covered beneficiaries. The numbers usually contain the beneficiary's nine-digit social security number followed by a letter. Sequences for beneficiaries with railroad Medicare numbers may start with a series of letters, and are usually followed by the social security number and end with a letter. The HIC number is a mandatory field on the Case File Transmittal Form.*

LEP/Creditable Coverage Corner

New Materials from CMS for LEP Assessment

CMS recently updated the model forms and related materials to be sent to beneficiaries to determine whether they had creditable prescription drug coverage prior to enrolling in a Medicare prescription drug plan, or during a break in Part D enrollment. Plans were to begin using these new forms with enrollments received on or after **April 1, 2009**. Neither the previous models nor the previously-approved notices should be used after that date.

Part D plans are required to mail an attestation form to solicit information about possible gaps in creditable coverage from beneficiaries who enroll in Medicare drug plans after they are first eligible, or who experience a break in coverage for a period of 63 or more consecutive days. (See CMS guidance at section 10.2 of Chapter 4: Creditable Coverage Period Determinations and the Late Enrollment Penalty (LEP)). The majority of requests for reconsideration of the LEP received by the Part D QIC are from beneficiaries who had creditable coverage during the period in question, but failed to submit or complete the attestation form. Moreover, plans are receiving questions from beneficiaries about the late enrollment penalty, why it is applicable, and what the term "creditable coverage" means. CMS addresses these issues in a set of questions and answers included with the new model forms. Note that CMS is using the phrase, "meets Medicare's minimum standards" instead of the term "creditable coverage" in these new materials. Many beneficiaries do not understand the term "creditable coverage," and this lack of understanding may be a barrier to their timely completion of the attestation form.

The attestation form itself has also been re-titled. It is now called the "Declaration of Prior Prescription Drug Coverage." Further, the notices associated with the new forms are now on Department of Health and Human Services/CMS letterhead and addressed directly to the beneficiary, to facilitate better beneficiary response. CMS created two versions of the cover letter that is to accompany the Declaration, depending on whether the enrollee is new to Medicare or is attempting to enroll subsequent to a break in creditable coverage. The "Frequently Asked Questions and Answers" document, also on CMS/Department of Health and Human Services letterhead, explains the late enrollment penalty and creditable coverage, and includes instructions on how and when to return the Declaration. This document further directs enrollees to three sources for additional information: their plan, 1-800 Medicare and Medicare's website. If a beneficiary does not return the Declaration page, the Plan can attempt to obtain a response by telephone, and/or send out a "Final Notice" to the beneficiary requesting a response. If the beneficiary still does not respond, s/he will be subject to the LEP.