LESSONS LEARNED AND INSIGHT INTO HANDLING PART D APPEALS, GRIEVANCES AND COVERAGE DETERMINATIONS

By
Lisa A. Hathaway. Esq.
Blue Cross and Blue Shield of Florida
• Part I-The Basics to Understand Part D Appeals, Grievances and Coverage Determinations
• Part II- Differences between Medicare Part C and Part D
• Part III- Legal Issues and Complexities
• Part IV- Latest Updates and Pointers
Part I

• THE BASICS

• To understand and legally support the operations areas that run Part D, you need to understand certain items.
  • Terminology
  • Time Frames
  • Other CMS Requirements
Key Terminology

- **Grievance** means any complaint or dispute, other than one that involves a coverage determination or a low income subsidy (LIS) or late enrollment penalty (LEP) determination expressing dissatisfaction with any aspect of a Part D plan operational activities, or behavior.

  - See 42 CFR 423.560 and CFR 423.566(b)

- **Coverage Determination** is the initial decision for what outpatient prescription drugs and the Plan will or will not cover.
• CMS indicates a Coverage Determination may include but is not limited to the following decisions:

1. Provide or pay for a Part D drug;
2. Amount of cost sharing for a drug;
3. Exceptions request;
4. Satisfaction of prior authorization or other utilization management request; or
5. Failure to provide a Coverage Determination in a timely manner when a delay would adversely affect the health of an enrollee.
Examples of Coverage Determinations

1. Whether or not a drug is medically necessary.
2. Whether a medication is on the formulary.
3. Deciding if a requested pharmacy is out of network.
4. Decisions on payment reimbursement requests.
5. Determining whether a drug falls in the exclusion list (benefit exclusion).
   - This could also be an “inquiry”.
Coverage Determinations Cont’d

6. Exceptions Requests such as:
   a. Tiered cost-sharing
      ex. Request of Tier 4 drug at Tier 3
      Request of Tier 3 drug at Tier 2
   b. Quantity Limits
   c. Step therapy requirements

If a Plan does not have a “open” formulary and has a more closed formulary, the appeal reasons may differ or be increased in number.
Redeterminations

• When an enrollee receives an Adverse Coverage Determination, the enrollee has 60 calendar days from the date of the Coverage Determination to ask for a Redetermination, unless good cause exists. This is really an “appeal”.

• Rule #1 - Must be conducted by a person who was not involved in the initial Coverage Determination.

• Rule #2 - If the determination involves a denial due to medical necessity, a physician with expertise and the appropriate level of training must evaluate the drug request. (Physician need not be of the same specialty or subspecialty as enrollee’s prescribing physician.)
Grievances, Coverage Determinations, and Redeterminations

• Can either be “standard” or “expedited”

• A “standard” Coverage Determination requires the Plan to notify the enrollee of its determination as “expeditiously” as the enrollee’s health conditions requires, but no later than 72 hours of receipt.

• An “expedited” Coverage Determination requires the Plan to respond within 24 hours or as “expeditiously as the enrollee’s health condition requires, but no later than 24 hours.
Grievances and Redeterminations

• Time Frame for Grievances
  – Expedited are 24 hrs, or as expeditiously as the enrollee requires, based on the enrollee’s health status.

• RULE: Grievances that are oral can be responded to orally or in writing. Grievances that are written must be responded to in writing.

• Time Frames for Redeterminations
  – 7 days for standard, whether or not the decision is favorable or not
  – 72 hours for expedited
Inquiries

• Inquiry: An enrollee’s request for coverage of a drug that is statutory excluded from coverage under Part D.

• CMS has now indicated that statutory excluded drugs **should not** be processed as coverage determinations, however, they may be in certain circumstances.

• **Caution:** Some enrollee complaints will involve drugs that are not statutory excluded, may not be excluded when used for a specific indication, or the drug could be covered as a Part D supplemental benefit, which would not be an inquiry.
For inquiries, a Plan must inform the enrollee or physician who has an inquiry about an excluded drug with the following information:

- Explain certain drugs are excluded.
- Explain the enrollee has a right to request a Coverage Determination.
- Explain the excluded drug is not covered as a supplemental benefit.
- Emphasize the enrollee should work with their physician to obtain a drug on the Plan’s formulary.
- See Model Letter.
Other Enrollee Appeal Steps After A Plan’s Coverage Determination

- Request a Redetermination
- Request a Reconsideration
- Request for Administrative Law Judge Hearing
  - Phone Conferences only
  - Amount in controversy must be met-$110
  - ALJs are now only in 4 locations, not local like with Medicare Advantage.
- Medicare Appeals Council Review
- Judicial Review
Reopening and Revising Determinations and Decisions

- Remedial action taken by the Plan, the IRE, ALJ or MAC to revise a decision.
- Set time frame of 1 year to 4 years, or any time for reliable evidence or an unfavorable decision.
- Requirements to reopen: 1) clearly stated with specific reason; 2) in writing; 3) and within certain time frame.
- Good cause requirement: 1) clerical error; 2) new and material evidence; and 3) clearly obvious error
PART II

• DIFFERENCES BETWEEN MEDICARE PART C AND PART D
Intricacies And Differences

- Medicare Advantage vs. Part D
- Terminology
- Different Complaint and Appeal Rights
- Timing differences
- Process
- Enrollee Involvement
- Reporting
- Dismissals
- Part B vs. Part D Drugs
Terminology

Medicare
- Uses “subscriber” & “organization”
- Organizational Determination
- Appeals are a “Reconsideration”
- IRE does the Reconsiderations
- All upholds that are adverse go to the IRE for final consideration

Part D
- Uses “enrollee” & “Plan sponsor”
- Coverage Determination
- Appeals are a “Redetermination”
- Plan does Redeterminations
- Only when time frame is missed or enrollee asks does it go to IRE
Terminology Continued

• Part D “Effectuation”- Compliance with a complete or partial reversal of a Part D Plan’s original adverse Coverage Determination. Compliance may entail payment of a claim, or authorization for, or provision of a benefit.

• Inquiry

• Complaint
Process Differentiation

Medicare Advantage
- All Grievances must be filed within 60 days.
- Region 4 indicated there is a “good cause” extension.
- Medical director signature required to send to CHDR.
- Enrollees are often not involved until later in the appeal process.

Part D
- Allows for “good cause” the Plan to hear a Grievance filed later than 60 days.
- Plan may extend for, good cause, the time for filing a request for a Redetermination.
- No medical director signature to send up to IRE.
- Enrollees are involved from the beginning.
Time Frame Differences

Medicare Advantage
• Longer time frames
• Appeals
  - 72 hrs expedited
  - 30 days standard, pre-service
  - 60 days standard, post service

Part D
• Short time frames
• Appeals
  - 24 hours for expedited
  - 72 hours for standard determinations
Time Frame Differences

Medicare Advantage
- Organizational Determination
  - 72 hrs expedited pre-service
  - 14 calendar days for standard pre-service
  - 30 calendar days, post service
- Extensions
  - 14 calendar day, if in beneficiary’s best interest

Part D
- Redeterminations
  - 7 days “standard”
  - 72 hours “expedited”
- No extensions
  - If time frame is missed, then Plan must be forwarded to IRE.
Appeals and IRE

Medicare Advantage
- Anything can be appealed. No denial is needed.
- Can appeal a perceived denial.
- Dismissals-CHDR must dismiss if there is no AOR, or when matter over 60 days.

Part D
- Can’t appeal unless a denial is made.
- Certain drugs are not part of the exception and appeals process
- Dismissals- The Plan does not have to send a request to the IRE for dismissal for no AOR or untimely AOR. The Plan does have to send a matter to the IRE for an untimely response or redetermination.
REPORTING

• Part D has more reporting.
• Part D-Number of grievances & number involving fraud & abuse, enrollment/disenrollment, benefit practices, pharmacy access/networks, marketing, customer service issues, and confidentiality & privileges.
  -Report no. of non-formulary exceptions and tier exceptions requests, appeals (standard vs. expedited, both Coverage Determinations and Redeterminations).
• Medicare Advantage reporting is suspended for appeals, at present.
  -Upon request of beneficiary, Plan must report number of appeals/quality care grievances.
PART III

• LEGAL ISSUES AND COMPLEXITIES
• Copayments
• Exceptions and Tiering
• Complaints-Grievances vs. Coverage Determinations or Both
• Quality of Care Complaints
• Tolling of Time Frames
• Prior Authorization and UM Requirements
• Part B vs. Part D Drugs
Co-Payments

- Co-Payments can be either a Grievance or a Coverage Determination.
- Plans must use a case by case determination.
- How to Distinguish:
  1. It is a Coverage Determination when an enrollee complains that the Plan made the enrollee pay a different co-sharing amount than the enrollee believes he or she is required to pay for a prescription drug.
  2. It is a Grievance when an enrollee expresses dissatisfaction that she has a 40% co-payment for a preferred drug.

-Key: Complaint is about part of the benefit structure.
Exceptions and Tiering

1. However, when an enrollee asks to receive a drug that is not preferred, at the preferred level due to medical necessity, this is an Exceptions Request.

2. It is a Coverage Determination when an enrollee is taking a drug and is notified the Plan is taking it off the formulary or is changing tiers.

3. It is a Grievance of when an enrollee who is not taking a drug finds it is being taken off the formulary.
Standards for Tiering Exceptions

- Example: When an enrollee requests a non-preferred Tier 3 level drug at the level of Tier 2, the brand level, due to medical necessity, this is a Tier Exception.

- Rule: Tiering Exceptions are required if the Plan determines the preferred drug for treatment of the enrollee’s condition, would not be as effective as the requested drug and/or would have adverse effects. 42 CFR 423.578(f)

- Rule: Cost sharing for approved tiering exceptions is at the preferred drug level.

- Note: Payment exception can run the rest of the year.
Tiering and Exceptions

- Rule: Plans have the flexibility to determine what single level of cost sharing will apply for all non-formulary drugs approved under the exceptions process.

- A Plan can apply the Non-Preferred level of cost sharing for non-formulary drugs approved as an exception. However, the level of cost sharing must be at the level of any of the Plan’s existing formulary tiers, including the high cost tier, as long as the level of cost sharing applicable to the high cost tier does not exceed 25% of the actual costs of the drugs contained in that tier.
CASE EXAMPLE

- Enrollee complains about a $30 co-pay for a brand name drug. Prescribing physician orders 40 day supply and co-payment was to be $60. Pharmacy charges the Enrollee $55 (cost of drug and dispensing fee). The Enrollee makes an oral complaint to the Plan indicating they are supposed to only pay $30 according to their EOC.

- Is this a Grievance or a Coverage Determination?

- What about the Pharmacy’s charge of $55 vs. $60?
Complaints & Grievances

- Some complaints are Grievances while others are Coverage Determinations.
- Grievances include any type of complaint by the enrollee such as:
  - Difficulty getting a customer service representative
  - Too long a wait time, rudeness of the pharmacy
  - Quality of care issues, benefits design
  - Failure of a plan to issue a timely decision
  - A Plan’s denial to expedite a Coverage Determination or a Redetermination
  - Appeals process complaints
  - Plan’s written communications, or written notices
Example

• Enrollee Sally goes to the Pharmacy with her prescription for Drug ABC. Pharmacy fills the prescription and she is told the cost is $--- as this drug is in Tier 3, the non preferred tier and co-pay is 50%. Sally requests a tiering exception, but under Plan X’s formulary, the Plan has exempted all Tier 3 drugs from the exceptions process.

• Is this a Grievance or Coverage Determination or an Exceptions Request?
Example

• Enrollee requests Drug ABC, which is an excluded Part D drug. Pharmacy provides the enrollee with the Pharmacy Notice. Enrollee then files a complaint that as the drug is excluded, but does not ask for the Plan to cover the drug.

• Is this a Grievance or a Coverage Determination?

• Same facts as above, but the Enrollee argues the drug is excluded for the purpose for which it is prescribed.

• Can the Enrollee appeal?
Quality of Care Complaints

- Ex. Pharmacy receives a prescription for Drug ABC and fills it with half of the ordered dose. The Pharmacy corrects the mistake, however the Enrollee complains in a call to the Plan. (Grievance)
- An Enrollee can file a Quality of Care complaint about a Part D drug with the Plan or address this through the QIO process, or both.
- See QIO Manual for process-Beneficiary Complaint Process
- Plans must timely submit information to the QIO.
Timing

• Part D timing is short.
• 24/7 processing of requests is required.
• A Plan cannot extend the time frame for responding by dispensing a temporary supply of the requested medications.
• Grievance - 24 hrs to 30 days
• Coverage Determinations - 24 hrs to 72 hrs
• Redeterminations - 72 hrs to 7 days
• Exceptions for tiering, step therapy, quantity limitations or prior authorizations: 1) start when the physician's oral or written supporting statement is received indicating one of the factors. See 42 CFR 423.578 (a) (4) or (b) (5).
Supporting Statements

- Where a supporting statement is required, CMS requires the Plan wait up for at least 24 hrs after the expiration of the time frame that the Plan would have had to make the Coverage Determination (i.e. A minimum of 48 hrs for expedited requests a minimum of 96 hrs of to receiving a standard request).

- Once the Plan receives the supporting statement, the time frame is tolled if the Plan requests additional information.
Supporting Statements

• The prescribing physician must state orally or in writing that the preferred drug for the treatment of the enrollee’s condition:
  1) would not be as effective as the requested drug;
  2) Would have adverse effects for the enrollee; and
  3) Or both of the above.

• Physicians can use any form or writing and do not have to use the Plan’s form.
Prior Authorizations

• A UM requirement could be a Grievance or a Coverage Determination or an Exceptions Request.

• Where a Plan denies payment for a covered Part D drug as the enrollee did not obtain prior auth or the request is denied for the requested drug, this is a Coverage Determination.

• The enrollee also has appeal rights for a denial.
• Ex. Plan subjects certain drugs to Prior Auths or other UM requirements. Enrollee complains that this drug has to be pre-auth’d.

• Ex. Physician submits records for an enrollee for Forteo. The Plan requires that an oral biphosphate, Fosamax, be used first. Plan denies the Forteo as no oral drug was tried first. This is consistent with the package insert for the drug.

- Subject to a Coverage Determination.

- Could be an exceptions request if Physician indicates adverse affects with an oral drug or any other drug but Forteo.
Part B vs. Part D Drugs

• Traditional Medicare A and B does not cover most outpatient prescription drugs.
• Medicare reimburses physicians for drugs and biologicals that are not usually self administered.
• Self administered drugs are not usually covered under Part B.
• The definition of a covered Part D drug excludes every drug which as prescribed and dispensed or administered to an individual, for which payments would be available under Part A and B.
Part D Drugs

• A Plan needs resources to distinguish B drugs from D drugs.

• Ex. Training of staff on obtaining information and to distinguish between drugs covered under Part B vs. Part D.
  -Gathering of facts, medical information.
  -Plan records that are available on line?

• Guidelines and Procedures

• CMS Resources
Part D Drugs

• Note: Plans can elect to include excluded Part D drugs as supplemental benefits provided such drugs meet the definition of a Part D drug except for non-prescription drugs. Note: Non-prescription drugs can be provided if they are part of a Plan’s utilization management program, such as step therapy, and can be provided at no cost to the enrollee.
  – However, the cost for such non-prescription drugs would fall in the Plan’s administrative cost.

• For 2007, a Plan can cover OTC drugs as either a mandatory supplemental benefit or as an optional supplemental benefit.
PART IV

• Tips and Compliance
• “Mine Fields”
Potential Compliance Areas

• Enrollees’ Perspective
• Physician involvement including supporting statement and making requests for Coverage Determinations and Exception requests
• Authorized Representatives (AORs)
• Medical necessity and certain Part D decisions; medical directors vs. pharmacists
• Documentation
• Pharmacy Notices
• Medical Exigency Standards
Enrollee Issues

• Not aware of rights or how to exercise
• Not aware of when a drug is denied that the drug may be covered under Part B
• No or limited access to the web or a computer.
• Physicians have no time or are unwilling to file the paperwork to support expediting or an exceptions or tier request.
• Mixed issues of Medicare Advantage and Part D and the different processes and forms
• Transition and transition supplies
• Out of network, prior auths, step therapy, tiering and quantity issues
Physician Involvement

• Key for expediting and supporting an enrollee’s medical necessity for a tiering, quantity, or step therapy exception.

• Coverage Determination requests are often denied as an enrollee often fails to provide enough information to support the medical necessity decision in his/her favor.
  -This included a lack of receipt of a physician supporting statement.

• If the Plan receives the Physician supporting statement and requests more information, the time frame is not tolled.
Physician Involvement

- A Plan can require the physician to submit the supporting statement in writing, but in exceptional circumstances, on a case by case basis, but the Plan may want an exception for an oral supporting statement for a physician who could not respond in writing due to justifiable circumstances.

- If the prescribing physician requests a standard or expedited C.D., or an expedited Redetermination, and the Plan misses the time frame and forwards to the IRE, Form CMS 1696 is required.

- A Plan cannot require a physician to submit a supporting statement on a specific form.
Case Example

– Ex. Coverage Determination for Humira. Physician did not send in supporting statement or any information. Enrollee history of being on the drug for 3 years. Denied due to no supporting statement. Enrollee appeals 30 days later. Now, has not been on this drug for 6 weeks.

– Issues:
  1) Risk of enrollee not being on the prescribed drug and whether the Plan’s record shows the drug history.
  2) What if pharmacist denied the initial Coverage Determination?
  3) What if when medical director, who reviews in the Redetermination approves?
  4) Liability Issues?
Appointed Representatives

- Three individuals can appeal under Part D-enrollee, prescribing physician, and appointed representative.
- Under Part D an enrollee can appoint any individual to act as his or her “representative”.
- CMS has a model AOR form, Form CMS 1696, that is to be followed, or the equivalent of this form.
- A valid authorized rep has all the rights and responsibilities an enrollee has.
- Know state laws on establishing “requisite” authority and provide guidance to staff.
Nuances with AORs

1. A signed CMS 1696 form must be included with each request for a Coverage Determination and Redetermination.

2. A signed AOR form is good throughout the entire appeal process as long as the original signed form is copied for the appeal.

3. A signed valid form is considered valid for one year and can be used with new appeals.

4. Requests for Coverage Determinations are not valid until the appropriate signed form is received.

   - A Plan must document reasonable efforts to obtain a signed AOR form.
5. A Plan should dismiss a Coverage Determination or Redetermination if the signed AOR form is not received in the appropriate time frame.
- Plan does not have to wait past the time frames.

6. Caution: The enrollee’s physician can request a decision on behalf of the enrollee, but is not the enrollee’s appointed representative and does not have all the rights and responsibilities of the enrollee, as an AOR has.
- An enrollee’s physician can request a Coverage Determination, but can only request an expedited Redetermination.
- The enrollee or AOR can request either a standard or the expedited Redetermination.
Medical Necessity Determinations

• Who makes these decisions at a Plan?
• How makes the Plan’s commercial HMO and Medicare Advantage Medical necessity determinations?
  – Medical Directors?
  – Outside Consultant Physicians?
  – Both?
• Which decisions for Coverage Determinations are within the realm of the pharmacist vs. the medical director?
Case Study Examples

• Prior authorization request for Lovenox, denied by Plan as documentation does not meet medical coverage guidelines. Enrollee has been on Lovenox for 3 years by syringe injection for diagnosis of CVA. On appeal, physician’s documentation reveals enrollee was on Coumadin then switched to Lovenox. History of three DVTs and needs an anticoagulant. Enrollee is 81, has Alzheimer’s and falls frequently leading to a dangerous situation if she is on Coumadin.

• Denying Lovenox due to no supporting statement.

• Potential Liability for Denial based on history.
Case Study Example

Ex. Enrollee on Procrit, which requires pre auth. Medical Coverage Guidelines (“MCG”) at the Plan require a certain HCT level for the use of this drug for a diagnosis of iron deficiency anemia. Enrollee does not meet the level for coverage required as based on the MCGs.

• Should a medical director make this decision or can a pharmacist?
Proper Documentation and Copious Paperwork

• Use of CMS letters or approved equivalent.
• Ex. “Request for Reconsideration Form” must be sent to each enrollee with an adverse determination notice. See Appendix 13
• Attach AOR forms with the Coverage Determination, Redetermination and any matters forwarded to the IRE.
• Document decision making, analysis, medical necessity, use of medical coverage guidelines.
• Maintenance of an inventory of case files forwarded to the IRE.
• Providing results of decisions to physicians.
Notice Requirements for Pharmacies

• Plans must arrange for network and preferred pharmacies to provide enrollees with a standard notice when the enrollee disagrees with the information relayed to them by the pharmacy.

• This standard notice also applies to long-term care pharmacies.
  – CMS indicates if the network pharmacy is off site, the pharmacy must send (fax or deliver) the notice to the LTC facility to the set location that is identified to receive such notices.
  – A copy of this notice is to be placed in the enrollee’s file of the LTC facility.
Medical Exigency Standard

• CMS requires the Plan make a decision as expeditiously as an enrollee’s health condition requires.
  – See 42 CFR 423.568 (c ), 423.572 (c ), 423.590 (c ) 423.590(d)(c ), 423.600(d), 423.638(c) and 423.638(b)
  – A Plan is required to use “acceptable standards of medical practice in assessing an enrollee’s medical condition”.
Medical Exigency Standard

– The Prescription Drug Benefit Manual indicates the enrollee’s diagnosis, symptoms, test results, and other indications from the provider should be taken into consideration for the time frame of decision making.

– CMS has indicated plans should not systematically take the maximum time permitted for making decisions.

– What criteria is used to decide the appropriate time frame?

– What data and records does the Plan and pharmacy have access to for decisions?

– Potential Compliance Area: Taking up to 72 hours for all Coverage Determinations or 7 days for all reconsiderations.

- Taking 24 hrs for expedited decisions may be supportable, but it will depend.
EXCEPTIONS

• **New**: If a Plan decides not to continue coverage granted under the exceptions process into the subsequent plan year, the Plan must send a written notice to that enrollee prior to the end of the plan year, unless the Plan clearly identified the date that coverage will end in its favorable decision letter.

• The notice must explain that the exception will not be extended, and provide the date that the exception will end.
PART IV

• Latest Updates and Pointers
Tips

• Proper interpretations of CMS requirements.
  - Clear procedures and desk tops
• Training and education and more training and education.
• CMS approved letters for varying situations requiring written responses for each Part D product.
• Language prompts for pharmacists and techs for notes and Coverage Determination letters to improve documentation and satisfy CMS requirements.

- Coverage Determination Worksheet
Tips

• Customer Service Representatives
  – Limits on their authority and parameters
  – Script of do’s and don'ts
  – Proper and professional documentation

• **Effectuating a Coverage Determination-Plan**
  approvals of requests must be carried out within a set time frame.

  1) If a Plan approves the request, the drug must be provided no later than 72 hours or 24 hours, if the request was expedited.

  2) Payment must be made within 30 calendar days after receiving the Coverage Determination request or physician supporting statement, if the Plan approves the request.
Tips

• CMS requires Plans to accept expedited Coverage Determinations both orally in writing.

• **Coverage Gap**-Enrollees still have Grievance and Appeal rights.

• Coordination between the Medicare Advantage and Part D areas
  – Ex: Mixed Appeals- Both Part D and Medicare Advantage issues
  – Relationship between the staff in compliance, medical management, pharmacy, Grievances, Appeals, and Coverage Determinations
  – Close Coordination is a **Must**.
Tips

• Redeterminations are to be maintained for a period of 7 years from the end of the year in which the final action occurs.

• At least 60 days advance written notice must be provided to enrollees for formulary changes.
  - If not 60 day supply of the drug with a notice must be given at refill.

• Information and manuals for physicians
  – Revision of the Physician Provider Manual
  – Website resources
  – Education
  – Consider “prompting” statements for the information required for the supporting statement.
Tips

• Mail Pick Up Times and Timing
  - Use certified mail or overnight
  - Requirement that the Enrollee/AOR and/or prescribing physician be mailed a written decision within 3 calendar days if the Plan makes an adverse notification orally.
  - If the Plan provides oral notification to the physician, written notification is not required.

• Audits and Compliance

• A Plan should make consistent decisions for tiering and exception requests and for non formulary requests.
• CMS’s Latest Requirements
CMS UPDATES

• CMS continues to post routine updates for Part D including for the Grievances, Coverage Determinations and redetermination area.
  - Last revision for Prescription Drug Manual on 6/06
• Frequent monitoring is required on the web for updates, questions and answers, releases, and memorandum.
• Plans will want to designate persons to monitor, analyze, and communicates updates to appropriate areas at the Plan.
CMS Updates and Changes

• CMS 24/7 call center requirements, which can include calls in the area of Grievances and Coverage Determinations.

• February 23, 2006-CMS requires Plans to have a toll free number for exception inquiries and appeals (and for enrollees and pharmacy help desk).

• CMS is requiring plans to create a streamline exceptions and appeals process by creating a website with as few of clicks as possible and a Resource Check List.

- On line forms, summaries of the process etc.
Ongoing Changes

- 2007 Transition requirements including enrollees rights to grieve and appeal.
- Transition process submission- Plans must show how the P & T committee will review and provide recommendations regarding procedures for medical review of non-formulary drug requests for 2007.
- Standard Exception form by JD Powers & Associates and the AMA.
- Pharmacy messaging code for notifying pharmacies when drugs are statutory excluded from Part D, but may be covered under Part B.
THE END

QUESTIONS

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Notes
Notes
Examples of Part B Drugs

– Drugs furnished incident to physician services (i.e. drugs administered by infusion or injections)
– Drugs billable as ESRD drugs
– Drugs provided in outpatient hospital departments
– Blood
– Drugs integral to a procedure such for diagnostic purposes or for a therapeutic service
– Drugs provided in certain provider settings such as ambulances, outpatient rehab facilities, etc.
Examples of Excluded Part D Drugs

- Drugs excluded from coverage under covered Part D
  - Drugs for anorexia, weight loss
  - Fertility drugs
  - Cosmetic drugs
  - Drugs for relief of cough or cold
  - Vitamins and Minerals
  - Non Prescription Drugs
  - Barbiturates
  - Benzodiazepines