

 GroupHealth.	HPD (Pre-Service, Member Appeals) Policies and Procedures
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Policy title Medicare Part D Expedited Appeal	Policy Number: MA 006 Adopted: 12/2005 Revised: 2/2006, 10/2006, 4/2007, 4/2008, 5/2009
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PURPOSE

EXPLANATION:

The Center for Medicare and Medicaid Services (CMS) has established policies for MA Part D appeals. CFR 42 423.584 provides that Part D plan sponsors will provide an expedited appeal procedure for certain issues that involve coverage determinations. The Group Health MA Part D appeal (redetermination) process is one step in a larger multi-level CMS-Part D appeal process, as provided in Title 42: Public Health, Part 423 - Voluntary Medicare Prescription Drug Benefit.

POLICY

DESCRIPTION:

This procedure was established to address the requirements defined in the Prescription Drug Benefit Manual Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals guidelines, Maximus Part D QIC Reconsideration Procedures, NCQA (UM 8,9), and Washington Administrative Code 284-43-620.

PROCEDURES

IMPLEMENTING PRE-SERVICE MEMBER APPEAL POLICY MA 005

Note: These procedures provide additional information related to Pre-Service Member Appeal MA006 policy, but are separate and distinct from that policy. Leadership retains discretion in implementing these procedures and can change them at any time, with or without notice.

PROCEDURE

Initial Steps (Administrative):

The Appeals Department receives a written expedited appeal request (letter, fax or e-mail) or verbal appeal request from a Group Health Medicare enrollee (or his/her prescribing physician or his/her representative) requesting expedited appeal of discontinuation or denial of coverage of a Part D prescription drug. (As noted previously, they may also request expedited reconsideration of discontinuation or denial of a prescription drug that is not included on the Part D Drug Formulary.) The 72 hour appeal time-clock begins on an expedited Part D appeal when the enrollee or enrollee's prescribing physician requests the appeal or when Group Health receives the completed Appointment of Representative Form/Healthcare Durable Power of Attorney Form confirming appointment by the enrollee of his/her representative or Durable Power of Attorney for this appeal. In addition to being valid for the life of the appeal, the Appointment of Representative Form is valid for one calendar year from the date it is signed and dated by the enrollee and the person accepting the appointment. Group Health also requests a completed Authorization to Release Healthcare Information Form if applicable. The Administrative Specialist will assign expedited appeal requests to a Case Manager on the same day as receipt of the expedited request. (If the expedited Part D appeal request is received during a weekend or holiday, the appeal will be assigned to a Case Manager on the first working day that the Appeals staff are back in the office.) Upon receipt of the written or verbal expedited appeal request, the Appeals Department Administrative Specialist will be the point of contact regarding the appeal request for the enrollee, the enrollee's prescribing physician or the enrollee's representative until the case is assigned to a Case Manager. (When a verbal request for appeal is made, the Appeals Department Administrative Specialist should process the request as follows: The request should be recorded in the enrollee's own words, repeated back to the enrollee to confirm the accuracy. Upon receipt of the written or verbal appeal request, the Administrative Specialist will:

1. Date and time stamp the request. If the request is made verbally, the date and time of the request is recorded on the Part D expedited appeal request form. All additional information and chronology provided by the enrollee at the time of his/her appeal request is also recorded on this form.
2. Review system documentation including the MCSS screen, for the enrollment status of the Medicare enrollee to determine applicable appeal pathway and appeal review timeframe.
 - Determine if the enrollee is locked-in to his/her Group Health Medicare Advantage Plan and if and when he/she elected the Part D prescription drug benefit.

3. Review for initiation of appeal request by qualified party:

- An expedited appeal request must be submitted by a Group Health enrollee or his/her prescribing physician, unless the enrollee has authorized, in writing, another party to be his/her representative for the appeal review process. (An enrollee's prescribing physician may request an expedited appeal on behalf of an enrollee without being the enrollee's appointed representative.)
- If the expedited appeal request is made by the prescribing physician, the request must be made specifically on behalf of the enrollee in order to be processed as a Part D prescription drug appeal. Physicians submitting expedited provider review requests (review requests that are not being made as the enrollee's representative) should be sent to our partner departments, such as Claims, CRU, or Provider Relations.
- If the appointed representative is an attorney, a signed and dated Appointment of Representative Form is not needed. However, the signed and dated Authorization to Release Healthcare Information is still required.
- If an unauthorized party requests an appeal review, and no formal written authorization of representation has been received from the Medicare enrollee, written notification is immediately sent, preferably by fax, to the unauthorized (second) party, informing him/her of this requirement. CMS regulations require that both parties complete and sign an Appointment of Representative Form in which the enrollee authorizes the second party to represent him/her in the appeal **OR** a copy of the Healthcare Durable Power of Attorney is provided which authorizes the second party to represent the enrollee in the appeal. Group Health also requests the signed and dated Authorization to Release Healthcare Information Form if applicable. Inform the unauthorized party that the expedited appeal timeframe begins upon Group Health's receipt of these completed forms.

4. Review for timeliness of submission of appeal:

- For Group Health Medicare enrollees, an expedited appeal request must be received by the Appeals Department within 60 calendar days of the date printed or written on the Initial Notice of Denial of Medicare Part D Prescription Drug Coverage, or if "good cause" is shown, Group Health accepts requests for standard reconsideration filed after 60 calendar days. (Prescription Drug Benefit Manual, Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals, Section 70.3 – Good Cause Extension). The request for extension of timeframe for filing appeal must be made in writing by the member or authorized representative.

Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

1. The enrollee was prevented by serious illness from contacting Group Health in person, in writing, or through a friend, relative, or other person;
 2. The enrollee had a death or serious illness in his or her immediate family;
 3. Important records were destroyed or damaged by fire or other accidental cause;
 4. Group Health or its designated entity, gave the enrollee, appointed or authorized representative, incorrect or incomplete information about when and how to request a redetermination;
 5. The enrollee, appointed or authorized representative, did not receive notice of the determination or decision; or
 6. The enrollee, appointed or authorized representative sent the request to another Government agency in good faith within the time limit and the request did not reach Group Health until after the time period had expired.
- Obtain a copy of the Notice of Denial of Medicare Part D Prescription Drug Coverage from the Group Health Pharmacy Help Desk to determine the date of notification of the previous denial.
 - If the request for appeal is received by the Appeals Department outside of the applicable appeal request timeframe:
5. Set up as an expedited Part D appeal case (See Secondary Steps) and open a case in E-Watson.
 - Assign the appeal case to Appeals Department Case Manager who will consult with the Appeals Department Supervisor, Pharmacy Help Desk Manager and/or Director of Medicare Administration, if appropriate.
 - The Case Manager will inform the enrollee, the enrollee's prescribing physician or the enrollee's representative verbally and by letter that his/her appeal request has been received too late for appeal. That letter will include the enrollee's right to file a grievance regarding Group Health's determination that his/her appeal request was received by Group

Health too late for appeal. The Case Manager will also advise the enrollee of his/her verbal right to request an expedited grievance.

- The Case Manager will document and close the case in E-Watson as “too late to appeal.”

6. Review request for “appealability” of issues:

- “Appealable” issues that meet Medicare criteria for expedited redetermination include pre-service denials for Part D prescription drugs, pre-service denials for prescription drugs that are **not** on the Part D Prescription Drug Formulary and discontinuation of coverage of Part D prescription drugs.
- Written or verbal requests that are not appealable (see definition of a grievance) are not subject to this procedure.

7. Review request for documentation of initial denial/discontinuation of Part D Prescription Drug coverage by Group Health Pharmacy Help Desk Pharmacist:

- Review the initial denial notice to make sure that it is the right notice. (The notice should match the contract.)
- If there is no documentation of a previous formal written denial (i.e., Notice of Denial of Medicare Part D Prescription Drug Coverage), the request cannot be reviewed through the expedited or standard 7 calendar day Part D appeal process until a formal written denial is issued. Clarify with the Medicare enrollee how he/she was informed of the discontinuation or denial of coverage of the prescription drug. Check E-Watson for documentation and contact the Group Health Pharmacy Help Desk to determine if a denial notice was onlined and sent to the enrollee.
- If records reflect that the enrollee’s request has been previously reviewed and formally denied in writing by the Pharmacy Help Desk Pharmacist Reviewer, accept the expedited request for the Part D prescription drug appeal review process, provided the request has been initiated by a qualified party, contains appealable issues, and has been received within the 60 calendar day timeframe.
- If the enrollee’s request has been previously reviewed by a Pharmacy Help Desk Pharmacist Reviewer, obtain a copy of the review and chart documentation used in the review from Lotus. (The chart documentation used in the review will be attached to the Lotus review worksheet.)

Secondary Steps (Administrative):

1. Enter the case into the E-Watson and Lotus systems as an expedited Part D pre-service appeal, as appropriate. A case should be opened the same day that the appeal request is received or within 24 hours of receipt of the appeal request.
2. Reference or attach copies of related pharmacy/prescription drug information obtained from the Group Health Pharmacy Help Desk and previous enrollee encounters regarding his/her Part D appeal issue (E-Watson system) in Lotus Notes.
3. Review the appeal request to determine if it meets criteria for expedited processing. If uncertain, consult with the appropriate Group Health physician to make the determination. If the request does not meet expedited criteria, notify the enrollee or the enrollee's representative by telephone immediately and in writing within 3 calendar days of the verbal notice.
4. Assign the case to a Case Manager if the expedited appeal request has been made by the enrollee or the enrollee's prescribing physician. In instances in which an unauthorized representative has requested the expedited appeal, assign the case to a Case Manager noting that the completed Appointment of Representative Form/Healthcare Durable Power of Attorney Form has not yet been received.
5. The Administrative Specialist and the Case Manager will consult to determine the scope of Group Health and non-Group Health medical records needed for review of the appeal case. Obtain copies of all medical records used by the Pharmacy Help Desk Pharmacist Reviewer in making the initial coverage determination denial. In most appeal cases, these medical records should be sufficient to provide a redetermination. For appeals that pertain to prescription drugs that are used to treat mental or chemical dependency issues, Group Health must obtain a separate medical release form signed by the enrollee in order to receive these particular records if they are from a non-staff model provider (either Group Health contracted or non-Group Health providers). Releases may not be required for staff-model mental health medical records. Obtain Group Health records from EPIC as appropriate. Order all pertinent non-Group Health medical records by faxed request and follow-up phone call.

Investigative Steps (Coordinator):

Upon assignment of the appeal case, the point of contact for the enrollee, enrollee's prescribing physician or the enrollee's representative is transferred from the Administrative Specialist to the Case Manager. All communications with the enrollee, the enrollee's prescribing physician or the enrollee's representative regarding the appeal will now be managed by the Case Manager. (The Administrative Specialist will be the point of contact only when the Case Manager is unavailable.)

1. Review copies of the Notice of Denial of Medicare Part D Prescription Drug Coverage from the Pharmacy Help Desk. Review the initial denial notice to make sure it is the right notice. (The notice should match the contract.) If the wrong notice has been issued, the Case Manager will effectuate an administrative overturn with the assistance of the Pharmacy Help Desk. The Case Manager will notify the enrollee, enrollee's prescribing physician, or the enrollee's representative in writing of GHC's administrative decision to cover the prescription for a specific amount of time.
2. A copy of the enrollee's Medicare medical coverage agreement, specifically the Part D prescription drug benefit agreement, is obtained and reviewed for areas that apply to the appeal issue.
3. All Group Health and Non-Group Health medical records are received and reviewed for documentation pertinent to the appeal case.
4. As the information that has been requested in steps 1-4 is received, it is date stamped and attached to the case file. If necessary, additional information is requested, either in writing or by phone, from appropriate staff and/or providers within the required time limits.
5. Prepare packet with all relevant documentation for the physician reviewer. **All Part D appeals require a physician review unless the Pharmacy Help Desk is going to authorize the prescription drug.** If Group Health cannot obtain all of the relevant documentation, Group Health must make the redetermination based on the material available. If Group Health does not provide the enrollee, the enrollee's prescribing physician or the enrollee's representative of a redetermination within the applicable timeframe, Group Health must forward the complete appeal case file to the IRE, MAXIMUS, for independent review no later than 24 hours after the expiration of the adjudication/reconsideration timeframe.
6. Document pertinent phone conversations in E-watson that are related to the appeal and place in the case file. Pertinent phone conversations may also be recorded on the communications log for inclusion in the case file. It is recommended that a telephone log (required by CMS) be maintained in the appeal case file.
7. If the Medicare enrollee, the enrollee's physician or the enrollee's representative, indicates that there has been a service breakdown (including misinformation provided by Group Health staff, untimely billings, untimely membership maintenance, access problems, etc.), a review of all of this documentation should be done. These complaints are considered Medicare grievances and must be responded to in writing along with the appealable Part D issue.

8. Correspondence is sent to the Medicare enrollee, the enrollee's prescribing physician or the enrollee's representative from the date the written appeal request is received by Group Health as follows:
- **The 72 hour timeframe begins the day of receipt of the appeal request. However, for appeals which require an Appointment of Representative Form/DPOA, if these forms are returned within the 72 hour timeframe, then a new 72 hour timeframe begins.**
 - Expedited Pre-service appeals -- Final redetermination letter: The expedited redetermination may initially be given verbally. However, if Group Health issues an adverse coverage redetermination in whole or in part, it must mail the enrollee written notice of the redetermination within 3 calendar days of the verbal notification. (If the enrollee's prescribing physician filed the expedited appeal request on behalf of the enrollee, Group Health must notify the enrollee and the enrollee's prescribing physician of the expedited redetermination.) **These letters must specify that they are providing a redetermination on a Part D appeal.**
 - All letters are attached to the enrollee's E-Watson case.
9. Periodic consultation may occur with the Pharmacy Help Desk Manager/Director of Medicare Administration during the appeal process.
10. If the enrollee, the enrollee's prescribing physician or the enrollee's authorized representative submits a written withdrawal request **before** Group Health has made its expedited appeal redetermination, the Case Manager should close the case as a "withdrawal". If the withdrawal request is received after Group Health has made its redetermination, the Case Manager must inform the IRE if the case has already been sent to the IRE.
11. If an enrollee has requested an expedited pre-service appeal but Group Health becomes aware that the enrollee has already obtained the prescription drug before Group Health completes its expedited redetermination, Group Health must stop processing the expedited pre-service appeal and instead process the claim as a standard 7 calendar day post-service appeal.. However, when the enrollee's appeal includes both a request for retrospective payment and an expedited request for pre-service Part D coverage, the case is processed as an expedited Part D pre-service appeal.
12. If the initial denial made by the Pharmacy Help Desk Pharmacist Reviewer is overturned as a result of an internal appeal review, the following steps must be accomplished as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date the request for expedited redetermination was received by Group Health for pre-service appeal:

- Immediately notify the enrollee of overturn administrative/contractual/clinical decision verbally within 24 hours and in writing within the 72 hour timeframe. Attach the letter to the E-Watson case.
- If applicable, email/call the appointed Pharmacy Help Desk Pharmacist to authorize coverage of the prescription drug. Document this in E-Watson within 24 hours of the coverage redetermination.
- If applicable, email/call the Pharmacy Help Desk Pharmacist (to initiate the claims payment). Document this in E-Watson.
- Close Vantive case.

13. If the initial denial is upheld as a result of an internal appeal review:

- Immediately notify the Medicare enrollee, enrollee's prescribing physician or the enrollee's representative verbally and in writing within the 72 hour timeframe, of Group Health's redetermination. The letter must include further appeal rights explaining that the enrollee can request another level of appeal by contacting the IRE directly within 60 calendar days of the date written on Group Health's Redetermination Denial letter.
- Attach the final redetermination letter to the E-Watson case. Complete E-Watson and Lotus case documentation and close the case.

GUIDELINES:

1. Timeliness

- The physician determination must be made within seventy-two (72) hours after the receipt of the appeal request.
- Upon receipt of the physician's determination, the Appeals Coordinator will contact the member or the member's representative by telephone to report the decision. The Appeals Coordinator will also send a redetermination letter informing the member of the appeal decision within the 72-hour time frame. If the decision is to uphold the denial, the letter will inform the member of the right to request another level of appeal by contacting MAXIMUS, the specified Independent Review Entity (IRE), within sixty (60) calendar days of the date of Group Health's redetermination denial letter.

2. Member Right to Representation

- A member may choose to have a representative file an appeal on his/her behalf; in this instance, the appeals process (adjudicatory time frame) begins when the appeal request and a written authorization of representation signed by the member, Durable Power of Attorney, or other legally binding document has been received by the Appeals Department. If someone other than the member requests an appeal without the appropriate authorization documentation, the Appeals Department will send the member an Appointment of Representative form and applicable Release of Health Care Information forms. If the representation documentation is not received within the time frame Group Health has for making its redetermination had the request been filed by the member, Group Health will dismiss the appeal on the grounds that a valid request was not received.

3. Role of the Appeals Coordinator

- The Appeals Coordinator is responsible for assuring that the Part D redetermination appeals process operates in a timely, efficient, and considerate manner.
- The Appeals Coordinator shall assist the member with the Part D appeals process. The Coordinator will ensure that the process is accessible for members who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that may impede their ability to file an appeal.
- If a member's request for coverage of a prescription drug is granted in part or in full, the Appeals Coordinator is responsible for providing timely notification to the member (or his/her authorized representative) and for assuring and coordinating the implementation of the decision.

4. Appeal (Redetermination) Procedures

- Written or verbal appeal requests for an appeal of an adverse initial coverage determination must be submitted within sixty (60) calendar days of the initial denial determination. The Appeals Coordinator will facilitate the appeal review.
- Appeals involving medical necessity:
 - a. A physician reviewer will review all Part D appeals. The physician reviewer will make the redetermination decision. The Appeals Coordinator shall accept the judgment of the medical staff with respect to the issue of medical necessity.
 - b. The reviewing physician shall be a reviewer not involved in the initial coverage determination, nor will the reviewer be a subordinate of the initial reviewer. The member's request will be

reviewed by or include a consultation with a health care practitioner with the appropriate expertise in the field of medicine that encompasses the member's condition or disease. Documentation of the consultation, including the consulting practitioner's name and qualifications, will be included in the appeal case file.

- Appeals involving legal, contractual, and/or risk management issues:
 - a. The Appeals Coordinator will consult with the Pharmacy Administration, Legal, Contracts and/or Risk Management Departments as appropriate. These departments will advise the Appeals Coordinator on the potential ramifications of any decisions.

5. Decisions

- Decisions resulting from the appeals process are not precedent setting.
- The case file prepared by the Appeals Coordinator will include:
 - a. An explanation of the decision, including the supporting coverage or clinical rationale.
 - b. The references to the specific MA Part D plan provisions/Medicare coverage regulation(s) on which the benefit determination is based.
 - c. Any and all applicable internal rules, guidelines, protocols, or similar criteria used in the decision process.
 - d. An explanation of the scientific or clinical judgment for the determination applying the terms of the member's medical circumstances.
 - e. The titles and qualifications of the individual(s) participating in the review.
 - f. A decision letter to the member using one of the CMS-approved or "deemed approved" template letters.

6. Member Access to Appeal Information

- Members will be provided, upon request and free of charge, "reasonable" access to and copies of all documents, records, and other information relevant to the member's appeal.
- Group Health Cooperative will provide, upon request and free of charge, the names of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a member's adverse appeal

redetermination, without regard to whether or not the advice was relied upon in making the benefit determination.

APPLICABILITY:

Group Health Medicare Advantage members, or their authorized representative, or the member's prescribing physician may request an expedited appeal either verbally or in writing. The appeal will be expedited if the member's treating provider or the review physician determines that the member's life, health, or ability to regain maximum function would be jeopardized by a delay in review, or that a delay would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Requests are automatically expedited when the request is made or supported by a prescribing physician. If the appeal request does not meet the criteria for expedited review, the appeal will be reviewed under the Medicare Part D Standard Appeal Procedure.

The expedited process applies to prospective appeals only and does not apply to Part D drugs already furnished.

The appeals process may make exceptions to Group Health policies or the Group Health MA Part D Formulary. Decisions resulting from the appeals process are made on a case-by-case basis, are customarily made as a result of consultation with the prescribing physician, and do not set precedent.

SCOPE:

This procedure applies to all Pre-Service Group Health MA Plan (locked-in) appeals of adverse initial coverage determinations that pertain to prescription drugs and that qualify for review on an expedited (72 hour) basis. The member who is the subject of the appeal must elect the Part D prescription drug benefit.

RESPONSIBILITIES:

Pre-Service Management team is responsible for implementation and oversight of this procedure and process.

REFERENCES:

Prescription Drug Benefit Manual, Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals, Sections 10-70.7.2.

Maximus Part D QIC Reconsideration Procedures Manual

Title 42: Public Health, Part 423-Voluntary Medicare Prescription Drug Benefit

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