

<b>Title: Mid Rogue Community Health Plan CareSource Policy for Part D Determinations and Appeals</b>		<b>Policy Number: PD005</b>	
<b>Department: Medical Affairs/Appeals &amp; Grievance</b>		<b>Effective: 01/01/2006</b>	<b>Date(s) Last Revised:</b>
<b>Approved By: (name/title)</b>			
<b>Written By:</b>			
<b>Reference: 42 CFR §423.562, 423.564</b>			

**Description:**

This document outlines CareSource’s policy for the levels of determinations for Part D Drugs.

Note 1: CareSource’s PBM (Pharmacy Benefit Manager), MedImpact will make the decision for Initial Determinations or Pre-Service Determinations if the request is made outside of CareSource’s usual business hours and on weekends.

Note 2: The drug benefit appeal levels are different from other appeals, because denials are not automatically sent to the Independent Review Entity (IRE) unless the determinations/re-determinations are not processed within prescribed timeframes; then, they must be sent to the IRE within 24 hours after the required timeframe expires.

**Policy**

1. Initial Determination—A decision is made to either cover or not cover the drug. Usually, this is done at the pharmacy level based on whether or not the drug is on the formulary for the condition.
2. Pre Service Determination—Called a “Coverage Determination;” this can be requested prior to the member’s going to the pharmacy to have the prescription filled. There are 2 levels for this determination—standard and expedited. For standard determinations, the decision must be made within 72 hours. For expedited determinations, the decision must be made within 24 hours.
3. Re-determinations can be requested when there is a denial for either the initial determination or the pre service determination. Re-determinations can be expedited or standard. Standard re-determinations must be processed within 7 days. Expedited re-determinations must be processed within 72 hours.
4. Reconsiderations are written requests from the member; they are filed after a redetermination denial. These are either filed directly with the IRE or sent to the IRE upon receipt.

5. ALJ Hearings are written requests from the member filed after a reconsideration denial. These are usually filed with the IRE which will then forward to the proper entity.
6. Medicare Appeals Council is the next level
7. Judicial Review is a civil action filed in a U. S. District Court.

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