

Title: Mid Rogue Community Health Plan – CareSource Expedited Redetermination Process—Part D	Policy Number: PD007 Appeals	
Department: Medical Affairs/Appeals & Grievance	Effective: 01/01/2006	Date(s) Last Revised:
Reference: 42 CFR §423.584, 423.586, 423.590 Medicare Manual		

PURPOSE:

The purpose of this document is to define and implement Expedited Redetermination process in accordance with CMS guidelines, which provides a timely and organized system for resolving member requests for Part D drug benefits.

POLICY:

The policy of CareSource is to utilize this document for processing a member, an authorized representative, or a physician request (on behalf of the member) for an Expedited Part D Drug Redetermination. The Medical Affairs Department will process a member request or physician request for a coverage decision as expeditiously as the member’s health requires but no later than 72 hours after receiving the request.

The following “re-determinations” can be requested: (1) a decision to provide or pay for a Part D drug (including a decision not to pay because the drug is not on the plan’s formulary, the drug is determined not to be medically necessary, the drug is furnished by an out-of-network pharmacy, or the plan determines that the drug is otherwise excludable under § 1862(a) of the Act); (2) decisions concerning an exceptions request; and (3) decisions on cost sharing amounts.

The procedures in the “Exceptions Process” should be reviewed when processing the drug redetermination requests.

The procedures contained in this document also includes those procedures set forth by external agencies involved in the CMS Appeals Process.

Note: Unlike the Medicare appeals process outside of Part D, denied re-determinations are not automatically sent to the Independent Review Entity (IRE). However, if the expedited redetermination is not processed within the time frame (72 hours), it must be sent to the IRE within 24 hours of the expiration of the time frame.

PROCEDURE:

- A. Receipt of Expedited Redetermination request from Member or Provider (on behalf of member):

1. An expedited redetermination request is received by Member Services or AGC via phone, FAX or in writing.
2. Member Services Representative (MSR) immediately forwards all requests to the Medical Affairs Appeals & Grievance Coordinator (AGC).
3. A telephonic request is received in CareSource Member Services. A Member Services Representative determines the member is requesting an expedited Part D Drug Coverage Redetermination and transfers call immediately to AGC.
 - Member Service Representative (MSR) explains to the member that the call is being transferred to AGC to speak with a RN Case Manager who will discuss the request for a an expedited redetermination.
 - AGC prepares written request and case summary into the membership system and forwards to RN Case Manager within 1 hour of receiving request.
4. A written request is initially received by Receptionist. The Receptionist date stamps the correspondence and immediately delivers to the Medical Affairs Department.
 - FAXED requests are received in the Medical Affairs Department and date stamped upon receipt of the FAX.
 - AGC records date of receipt of forwarded correspondence and forwards the written request to the RN Case Manager.
 - AGC prepares written request and case summary and forwards to RN Case Manager within 1 hour of receiving request.
5. Expedited Criteria: The Medical Affairs staff should consider the expedited requirement met if the lack of the drug(s) has the potential to adversely affect the member's health.
 - If Medical Affairs decides that the request does not meet expedited criteria, AGC sends written notification to member of denied expedited request within 24 hours of member's request. The denial notice explains that the request is being transferred to the Standard Redetermination Process (7 days). The notice provides the member with rights to file a Formal Grievance and rights to submit evidence.
6. AGC sends written notification to member within 72 hours of member's expedited redetermination request.

B. Initial Expedited Case Development

1. AGC contacts the member, if necessary, via telephone to obtain all pertinent information to develop case.
 - AGC informs member of the right to submit evidence.

- AGC documents all conversations with the member into the EZ Cap tracking system.
2. AGC request medical records, if applicable.
 - AGC contacts providers, if applicable, within 24 hours of receipt of request, to request medical records and delivery of those records by overnight mail service or FAX.
 3. AGC prepares case and submits to Physician Reviewer for medical determination within 1 day.

C. Case Review Completed

1. Physician Reviewer reviews case file and reaches decision within 1 day.
2. Physician Reviewer returns case file to the AGC with case decision.
3. Decision to Pay for Drug(s):
 - Medical Affairs authorizes drugs as expeditiously as member's health requires but no later than 72 hours from receipt of member's request.
 - AGC notifies member orally or in writing drugs are authorized within 72 hours of member's request.
 - AGC enters all information into tracking system.
4. Decision Upheld:
 - AGC notifies member of decision and, if applicable, the physician, either orally or in writing, within 72 hours of the initial receipt of the redetermination request. Member is informed of right to reconsideration and that it must be requested in writing within 60 calendar days.

D. Independent Review Entity (IRE) Review

If the plan does not make a coverage determination within 72 hours, it must send the file to the IRE:

1. AGC forwards case file to IRE within 24 hours of the expiration of the timeframe (72 hours).
2. IRE sends CareSource and the member an acknowledgement letter by regular mail
3. AGC responds to IRE's telephone or email request for additional information.

4. IRE will notify plan and member of decision. If IRE decides to pay for drug(s), follow C.3.