

Title: Appeals Part D Standard Reconsideration	Policy Number: PD008 Appeals	
Department: Medical Affairs/Appeals & Grievance	Effective:	Date(s) Last Revised:
Approved By: (name/title)		
Written By:		
Reference: CFR 42 §423.600		

PURPOSE:

The purpose of this document is to define and implement an appeal process for a Standard Reconsideration of a member, authorized representative, or physician requests for a denied drug coverage or drug payment that a member believes he or she is entitled to.

POLICY:

- A member who is dissatisfied with the redetermination has a right to a reconsideration by the Independent Review Entity (IRE) that contracts with CMS. The member must file the written request within 60 days of the redetermination decision.

PROCEDURE:

A. Receipt of a Written Reconsideration

1. Mail is date stamped and delivered daily to the Medical Affairs Appeal & Grievance Coordinator (AGC)
2. AGC date stamps and reviews all incoming mail including faxes
3. AGC sends acknowledgement letter to the member within 1 day notifying the member their reconsideration has been received by CareSource and will be forwarded to the Independent Review Entity.

B. IRE Processing of Reconsideration

1. AGC prepares case for review by IRE
2. AGC prepares case for submittal to IRE using mandated forms and documents within 1 calendar day from the date of the member's request for a reconsideration

3. AGC includes “Case Material” to all supporting notices, documentation, medical records, and call logs. Case Material documents must include, but are not limited to the following:
 - Notices
 - Appointment of Representative (if applicable)
 - Provider Waiver of Liability (if applicable)
 - Notice of CareSource’s adverse determination
 - Claim denial documents
 - Medical Director or physician consultant documentation
 - Documentation of arguments of member, member’s provider, or representative
 - Provider letters supporting the member’s position
 - Relevant call logs or system reports
 - Other records kept by CareSource of its initial determination or reconsideration
 - CareSource’s decision making criteria
 - Complete copy of formulary exception policy for pharmacy reconsiderations
 - Citation for any CMS policy references, or copy of text
 - Medical records
 - Complete copy of any referenced internal medical policy, utilization review criteria,
 - Other pertinent information
4. AGC mails case file to IRE within 1 calendar day.
5. AGC enters all information into the EZ Cap tracking system

C. IRE Review

1. The IRE is required to solicit the views of the prescribing physician, orally or in writing. A written account of the physician’s views must be contained in the IRE’s record.
2. For an enrollee to request an IRE reconsideration of a plan’s determination not to provide for a covered Part D drug that is not on the formulary, the physician must determine that all covered Part D drugs on any tier of the formulary for treatment of the same condition would not be as effective for the individual as the nonformulary drug, would have adverse effects for the individual, or both.
3. The IRE must conduct the reconsideration as expeditiously as the member’s health condition requires but must not exceed the deadlines specified in its contract, including those deadlines that are applicable when a request for an expedited reconsideration is received and granted.
4. When the issue is coverage based on a lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), the reconsideration must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue. The physician making the reconsideration need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.

D. IRE Decision

1. The IRE must mail a notice to the enrollee, the plan, and CMS. The notice must:
 - State the specific reasons for the IRE's decision in understandable language;
 - If the reconsideration is adverse (does not completely reverse the adverse coverage decision), inform the enrollee of his or her right to an ALJ hearing if the amount in controversy exceeds the thresholds established by the Secretary;
 - Describe the procedures to be followed to obtain an ALJ hearing; and
 - Comply with other requirements specified by CMS
2. Decision Reversed:
 - IRE notifies CareSource and the member of reversed decision.
 - CareSource must authorize payment (if payment was denied) for the drug benefit within 7 calendar days after the date that CareSource receives notice and make the payment no later than 30 calendar days.
 - CareSource must authorize or provide the drug benefit within 72 hours after receiving the notice from the IRE.
 - AGC enters all information into EZ Cap tracking system and closes case

E. Administrative Law Judge (ALJ) Hearing

1. Member submits request for an ALJ Hearing in writing to any of the following: CareSource, SSA Office, RRB Office or IRE. The requests must be immediately forwarded to the IRE for processing.
2. IRE prepares member's case file and forwards to the ALJ Hearing Office
3. The Office of Hearing and Appeals contacts the member and CareSource to schedule a hearing
4. ALJ conducts hearing and makes determination
5. Decision Overturned:
 - ALJ sends determination notice to CareSource member and IRE
 - IRE sends written notification to CareSource and a copy to the member to comply with the ALJ decision
 - AGC arranges for claims payment or reimbursement to the member within the established timeframes from receiving notice from ALJ
 - AGC sends effectuation of claim payment or reimbursement to IRE within 1 business day of claim payment

- AGC enters all information into EZ Cap tracking system and closes case

6. Decision Upheld:

- CareSource and member is notified in writing of upheld decision by ALJ
- AGC enters all information into EZ Cap tracking system and closes case

F. Departmental Appeals Board (DAB)

1. CareSource or member submits a written request for a hearing before the DAB within 60 calendar days of the filed date receipt of the ALJ Hearing decision or dismissal

2. DAB is provided a copy of the entire case in dispute by the CHDR

3. DAB schedules Hearing

4. DAB conducts review and reaches decision

5. Decision Overturned:

- DAB notifies CareSource and member in writing of overturned decision
- AGC arranges for claim payment or authorization of drug benefit within prescribed timeframes.
- AGC notifies member in writing of claim payment or drug authorization
- AGC sends effectuation of claim payment or drug authorization to IRE within required timeframes.
- AGC enters all information into EZ Cap tracking system and closes case

6. Decision Upheld:

- CareSource and member is notified in writing of upheld decision by DAB
- AGC enters all information into EZ Cap tracking system and closes case

G. Judicial Review

1. CareSource or member request a Judicial Review if amount in controversy is \$1,000 or more

2. CareSource or member must file a civil action in a district court of the United States where the member resides or the plan's place of business

3. Judicial Court makes decision on case and notifies CareSource and member of decision

4. Decision Overturned:

- AGC arranges for payment or drug authorization within required timeframes.

- AGC notifies member in writing of claim payment or reimbursement
- AGC enters all information into EZ Cap tracking system and closes case

5. Decision Upheld:

- Judicial Court notifies CareSource and member in writing within 60 calendar days of upheld decision
- AGC enters all information into EZ Cap tracking system and closes case

H. Reopening & Revising Determinations & Decision

1. CareSource or the member submits a written request for an administrative reopening of a case
 - Reopening occurs generally to correct an error in response to suspected fraud
 - In response to receipt of information not available or known to exist at the times the complaint was initially processed (a reopening is not an appeal right)
2. The filing of a request for a reopening does not relieve CareSource of their obligation for payment

I. Guidelines for a Reopening

1. Request must be made in writing and clearly stated
2. Request must include the specific reason for reopening request
3. Dissatisfaction is not grounds for requesting a reopening
4. Request should be made:
 - Within 12 months of the date of the Initial Organization Determination or Reconsideration Determination
 - After 12 months, but within 4 years of CareSource's Initial Organization Determination or Reconsideration Determination

J. Good Cause for Reopenings

1. There is new and material evidence that was not readily available at the time of the determination or decision and consideration of this material may result in a different conclusion
2. There is a clerical error in the file
3. An error exists on the face of the evidence, which affects the determination or decision