

Title: Mid-Rogue Community Health Plan - CareSource Standard Re-determination Process—Part D	Policy Number: PD008 Appeals	
Department: Medical Affairs/Appeals & Grievance	Effective: 01/01/2006	Date(s) Last Revised:
Approved By: (name/title)		
Written By:		
Reference: 42 CFR §423.580, 423.582 Medicare Manual		

PURPOSE:

The purpose of this document is to define and implement Standard 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 a Standard 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 7 days 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.

See the Exceptions Process for general guidance.

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

Note: The drug redetermination request is not automatically sent to the Independent Review Entity (IRE) if it is denied. However, if the drug redetermination request is not processed within 7 days, it must be sent to the IRE within 24 hours of the expiration of the timeframe.

PROCEDURE:

A. Receipt of Standard Redetermination request from Providers or Members

1. A 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 a 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 an RN Case Manager who will discuss the request for a drug coverage redetermination.
 - AGC prepares written request and case summary into the membership system and forwards to RN Case Manager within 1 day 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 day of receiving request.
 - AGC sends written notification to member within 7 days of member's redetermination request.

B. Initial 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 requests medical records, if applicable
 - AGC contacts non-contracted 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 a drug coverage determination within 2 days.

C. Case Review Completed

1. Physician Reviewer reviews case file and reaches decision within 2 days.
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 10 days from receipt of member's request.
 - AGC notifies member orally or in writing that drugs are authorized within 7 days of member's request.
 - AGC enters all information into the EZCap tracking system.
4. Decision Upheld:
 - AGC notifies member of decision and, if applicable, the physician either orally or in writing within 7 days 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 7 days, it must send the file to the IRE:

1. AGC forwards case file to IRE within 24 hours of the expiration of the timeframe (7 days).
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.