Division of Appeals – Part D

Frequently Asked Questions

Coverage Determinations vs. Redeterminations

Question: If a request is received by a plan that includes the same medication and same dose for a beneficiary as a previously denied coverage determination but was prescribed by a different prescriber, should this be processed as a redetermination or a new coverage determination?

Answer: CMS expects the plan to process a denied request for the same drug, same dose and same prescriber as a redetermination. If they receive a request for the same drug, different dose, and/or different prescriber, we would expect that to be processed as new coverage determination.

Appointment of Representative (AOR)

Question: In the event a prescriber's staff member at the prescriber's office submits a coverage determination, on behalf of that prescriber, can CMS advise if the plan should proceed with the coverage determination or request an AOR from the member?

Answer: CMS regulations allow a prescriber to request a coverage determination or redetermination on an enrollee's behalf, and CMS believes this reasonably extends to the prescriber's office staff. CMS expects the plan to process such requests within the appropriate adjudication timeframe and is not permitted to require an AOR.

This applies to both C and D.

Denial Notice

Question: Please clarify the instructions for the Part D denial notice? When applicable, are plans allowed to place the bracketed language above the "you should share a copy" sentence?

Answer: Plans are allowed to reorder applicable bracketed language (i.e. Language to be inserted for prescription drugs that may be covered under Medicare Parts A or B) as long as that language is placed below the "Why Did We Deny Your Request" header.

Exceptions/Excluded Drugs

Question: How should a plan process an appeal for coverage of a non-Part D or excluded drug?

Answer: If a plan sponsor receives a valid coverage determination request for an excluded drug, the plan must issue an adverse decision explaining that certain drugs are not covered Part D drugs, or are excluded from coverage under Part D - and the requested drug is one of those drugs and the member must be given appeal rights.

Grievances

Question: A number of plans have asked whether a plan should log a Grievance if there is an expression of dissatisfaction but the member specifically states they do not want to file a grievance. Practice varies among plans.

Answer: For grievances, if an enrollee calls the plan with a complaint/grievance, but it is resolved during the call with the customer service representative, it would be classified as a grievance even if the issue is resolved during the initial call and no further action is required. Grievances may be filed orally and resolved/responded to orally. These enrollee communications are grievances by the nature and content of the communication with the plan and there is no necessity or reason for the plan to ask the enrollee “do you wish to file a grievance.” The plan must document the call (including date of receipt), the issues that were raised during the call and the resolution (including date of resolution).