

Hospice FAQs (v.08.06.14)

Q1: Part D sponsors provide a contact number to the pharmacy on the E1 query response and may include a contact number in the free text messaging returned in the claim response. Is it acceptable for a sponsor to provide a different contact phone number on the response to a claim being rejected for a beneficiary-level hospice prior authorization (PA) than the contact number reported on the E1?

A1: It is acceptable to have different numbers. However, if a different number is used on the claims reject, we expect it would be specific to the coverage determination and PA process. Since hospices may use the pharmacy help desk number to initiate communication with the sponsor, persons staffing this number should be prepared to either accept and document the information or forward the callers to staff who can.

Q2: What are the timeframes for sponsors to adjudicate beneficiary-level hospice PA requests?

A2: When a coverage determination is requested by the beneficiary, his/her appointed representative or the prescriber, the threshold issue is whether the beneficiary-level hospice PA has been satisfied; that is, whether a statement of the unrelatedness (of the prescribed drug) to the terminal illness or related conditions has been received by the plan sponsor. If the plan sponsor already has that information based on the communication and coordination contemplated under the guidance, the adjudication timeframe of 24 hours (expedited) or 72 hours (standard) starts when the plan receives the coverage determination request. If the plan receives a coverage determination request and does not have the information necessary to satisfy the beneficiary-level hospice PA, the applicable timeframe begins when explanation statement indicating the drug is unrelated to the terminal illness or related conditions is received by the plan sponsor from the hospice provider or prescriber. As noted in the addendum to July 18, 2014 guidance memo, the adjudication timeframe can only be tolled for a reasonable period of time pending receipt of the information necessary to satisfy the beneficiary-level hospice PA. The plan sponsor must promptly solicit any information it needs to satisfy the PA.

Q3: Can a hospice submit a coverage determination request in response to a claim reject at point-of-sale (POS) for a beneficiary-level hospice PA?

A3: Federal regulations at 42 CFR 423.566(c) limit requests for a coverage determination to the enrollee, the enrollee's appointed representative on behalf of the enrollee, or the prescriber on behalf of the enrollee. However, if a claim has been rejected by a sponsor due to the beneficiary-level hospice PA, the hospice provider may contact the Part D sponsor to provide an oral or written statement or provide a written statement to the pharmacy or the beneficiary to transmit to the Part D sponsor indicating the drug is unrelated. The sponsor should accept this information to override the POS reject without requiring that the beneficiary, or others on their behalf, request a coverage determination. Once a coverage determination is requested, the sponsor should accept and use the statement that the drug is unrelated to the terminal illness and/or related conditions provided by either the prescriber or hospice provider.

Q4: When a hospice submits information to a Part D sponsor prior to a claim submission for a hospice beneficiary, is this considered a PA or coverage determination request?

A4: A hospice may initiate communication with the sponsor to provide information on the hospice election and/or information on any drug the hospice has determined may be covered under Part D, indicating the drug is unrelated to the terminal illness and related conditions. However, this communication is not a coverage determination or PA request. Providing information that a drug is unrelated in advance of a claim submission does eliminate the need for a beneficiary-level hospice reject thus avoiding a coverage determination or PA.

Q5: The POS reject message recommended by CMS (i.e., Hospice Provider- Request Prior Authorization for Part D Drug Unrelated to the Terminal Illness or Related Conditions) appears too long for the text message field; is a shorter message acceptable?

A5: The message “Hospice Provider-Request PA” is being used within the industry and would be acceptable. NCPDP may have alternative messaging that also would be suitable.

Q6: What is the Part D sponsor’s responsibility when a prescriber unaffiliated with the hospice does not respond to a request for an attestation that he or she has conferred with the hospice?

A6: The guidance indicates that the sponsor may contact the hospice if an unaffiliated prescriber is unable or unwilling to coordinate with the hospice to provide the statement indicating the drug is unrelated for the PA. We believe that unaffiliated prescribers should attest that they have coordinated with the hospice, but do not specify any sponsor follow-up should the prescriber fail to attest to this coordination. However, we note that the sponsor may fax an informational copy of the completed PA form to the hospice when the prescriber was determined to be unaffiliated.

Q7: What documentation is necessary from a prescriber unaffiliated with the hospice to establish the drug is unrelated to the terminal illness and related conditions and to attest that he or she has conferred with the hospice?

A7: The documentation for an unaffiliated provider to establish that a drug is unrelated is the same as for an affiliated prescriber. That is, a statement indicating that the drug is unrelated. The form developed by the industry in conjunction with the NCPDP Hospice Task Group to report the information needed to override a hospice-related PA edit contains a question on the first page below the prescriber signature to which an unaffiliated prescriber may respond to indicate he/she has confirmed with the hospice that the medication prescribed is unrelated.

Q8: In lieu of instructing the pharmacy on how to override the edit once the PA is approved, is it acceptable for the sponsor to provide a code to the pharmacy that would permit the claim transaction to process?

A8: Provision of a code to the pharmacy allowing the transaction to proceed is acceptable. Notification to the beneficiary is also required.

Q9: Will Part D sponsors continue to be responsible for recovering the 2011 and 2012 Part D paid claims previously identified as duplicate payments by CMS' Center for Program Integrity (CPI) or can sponsors resubmit prescription drug event (PDE) records for these claims?

A9: Despite the prospective application of the March 10, 2014 guidance, the claims for analgesics for hospice beneficiaries paid under Part D in 2011 and 2012 previously identified in CPI issued memoranda (dated June 24, 2013, August 5, 2013 and August 8, 2013) must be deleted. In our October 30, 2013 memorandum clarifying the recovery of Part D payments for these analgesic claims, we noted that, consistent with our payer-to-payer reconciliation policy addressed in Chapter 14 of the Medicare Prescription Drug Benefit Manual section 50.14.4, we expect Part D sponsors to handle the payment resolution directly with hospices without involving the pharmacy, that is, without recouping funds from the pharmacy or requiring the pharmacy to reverse the original claim. We also indicated that in those instances in which the sponsor had already either recouped the payment from the pharmacy or required the pharmacy to reverse the original claim, if the pharmacy is still holding a receivable for the drugs, we recommend that the Part D sponsor undo the pharmacy recoupment and recover the payment from the hospice. To the extent that these circumstances still exist, that recommendation is still applicable. The July 18, 2014 memorandum does not alter this guidance.

Q10: Since the July 18, 2014 guidance is effective upon issuance, what policy should be used to resolve coverage for drug claims received prior to that date for Part D payment for beneficiaries enrolled in hospice?

A10: For 2014, drugs outside the four categories (i.e., drugs other than analgesics, antiemetics, laxatives and anxiolytics) should no longer to be subject to hospice PA reject edits. Any coverage determinations that are pending for previously rejected claims for these drugs should be resolved without the sponsor obtaining documentation regarding the relatedness of the drug to the terminal illness and related conditions. However, all non-hospice-related PA and Part D review requirements should continue to apply to these claims. Any coverage determinations that are pending for previously rejected claims for drugs in the four categories should be resolved.

Q11: If a claim is retrospectively determined to be a member liability and the sponsor collects from the beneficiary, must the sponsor request the pharmacy reverse the claim and/or delete the PDE?

A11: Drugs that are waived through the hospice election are drugs that are related to the terminal illness and related conditions and are, therefore, not covered under Part D. The sponsor must delete the PDE for the claim and remove the costs from the member's accumulators (i.e., TrOOP and gross covered drug costs.) Since the sponsor is recovering the plan paid amount from the member, the sponsor should not require the pharmacy reverse the claim.

Q12: What is necessary when an approved PA is in place and the drug subsequently must be subject to a beneficiary-level hospice PA?

A12: Drugs in the four categories that were previously subject to a drug-specific PA will require a beneficiary-level hospice PA under the revised guidance issued on July 18, 2014. There would be no need to reevaluate the drug-specific PA. The beneficiary communication should differentiate between the drug-specific PA which is already in place and the beneficiary-level hospice PA.

Q13: CMS recently announced a new hospice-type demonstration, the Medicare Care Choices Model. How does the final CMS hospice guidance apply to beneficiaries who participate in the new demonstration?

A13: Beneficiaries participating in this demonstration will not be electing the hospice benefit. They will continue to receive curative services and certain other services usually provided by a hospice such as dietary counseling. Since there will be no hospice election, prescription drugs would not be subject to a beneficiary-level hospice PA and would be coverable under Part D.

Q14: The guidance issued on July 18, 2014 specifies that, although the guidance is effective as of the date of issuance, Part D sponsors will require some time to implement the changes and, thus, are expected to implement on or before October 1, 2014. Are hospice providers also afforded time to implement?

A14: Yes, we recognize that the revised guidance will require hospice providers to implement changes to effectuate the policy and we expect that this will be done as soon as possible and all hospice providers will have implemented the changes by October 1, 2014.

Q15: If the Part D sponsor accepts and uses the prescriber's or hospice provider's statement that the drug is unrelated to the terminal illness and related conditions, will documentation of that statement be satisfactory evidence that the drug is coverable under Part D for audit and other program oversight purposes?

A15: Part D sponsors should accept an oral or written statement indicating that a drug in the four categories is unrelated to the terminal illness and related conditions from the prescriber or hospice provider or a written statement from either the prescriber or hospice that is transmitted to the sponsor from the pharmacy, the beneficiary or another person acting on the beneficiary's behalf. The Part D sponsor should use this information to override the point-of-sale hospice PA edit and retain documentation of the statement that the drug is unrelated to support coverage of the drug under Part D. Sponsors are not expected to place hospice PA requirements on drugs outside the four categories, or take special measures beyond their normal compliance and utilization review activities, or retrospectively review paid claims for purposes of determining whether the drug is unrelated or payment recovery. We expect that claims for drugs outside the four categories when submitted to Part D are unrelated to the terminal illness and related conditions and therefore may be coverable under Part D.

Q16: May a sponsor accept notification of the termination of the hospice benefit from the hospice, the beneficiary, or the prescriber? What notification is provided to the beneficiary and what is the lag in reporting the information to the Part D sponsor?

A16: Yes, if the termination of the hospice benefit is not yet reflected in the CMS systems, a sponsor may accept documentation of the termination whether due to the beneficiary's revocation of his or her election or a hospice discharge or other termination. Documentation may be accepted from the hospice, the beneficiary, or a prescriber.

Acceptable documentation is dependent upon the reason for the termination. If the beneficiary revokes, he or she provides a written statement to the hospice that indicates the date the revocation is to be effective. If the hospice initiates a discharge, it provides a Notice of Medicare NonCoverage (NOMNC) to the beneficiary if the discharge is because the beneficiary is no longer considered "terminally ill." A NOMNC is not provided if the beneficiary is discharged for cause, or because of moving out of the service area. The hospice is expected to discharge the patient to a facility or back to his/her primary physician. As such, the hospice is required to provide the discharge summary to that follow-up provider.

CMS systems are updated to reflect the beneficiary is no longer in hospice when the hospice files either the final claim or a notice of termination or revocation. There are currently no timeframes for the filing of a notice of revocation or termination, and providers are allowed 12 months from the date of service to file the final claim. Once the final claim or notice of termination/revocation is filed by the hospice with the Medicare Administrative Contractor and the CMS Common Working File is updated, within 2-3 days the daily transaction reply report (DTRR) will report the termination to the Part D sponsor.

Given the potential length of the reporting lag, sponsors should use the highlighted documentation (i.e., written statement of revocation, NOMNC, or copy of the hospice discharge summary) presented by the hospice, beneficiary or prescriber to update their systems pending the receipt of the DTRR reporting the termination or the end of the current benefit period, if earlier. Unless a new benefit period start date is reported, sponsors may use the documentation to remove the beneficiary-level hospice PA edit.

Q17: If a sponsor disagrees that a drug is unrelated to the terminal illness and/or related conditions, must the sponsor accept the statement?

A17: Yes. While sponsors might question that a drug is unrelated, they nevertheless need to accept the statement that a drug is unrelated to the terminal illness and related conditions from either the hospice provider or the prescriber, even when unaffiliated with the hospice, document the statement and process the claim. Since there is no dispute resolution process, the statement that the drug is unrelated should be used to support coverage of the drug under Part D and any additional explanation of unrelatedness provided by a hospice provider or the prescriber should be ignored.

Q18: Is there a definition of "related condition"?

A18: In the FY 2014 hospice final rule, CMS clarified that all of a patient's coexisting or additional diagnoses related to the terminal illness and related conditions should be reported on the hospice claim. We also stated that when an individual is terminally ill, many health problems are brought on by underlying conditions, as bodily systems are interdependent, meaning that there are

multiple conditions, and hence diagnoses, contributing to the terminal prognosis (78 FR 48247). Our expectation is that hospices will follow ICD-9-CM coding guidelines for listing all diagnoses for the terminal illness and related conditions on the hospice claim.

Q19: Can a hospice request an E1 eligibility query? How would a hospice pharmacy access E1 capability, if the pharmacy does not have this capability currently?

A19: No, a hospice cannot request an E1 eligibility query. The E1 query is only a pharmacy transaction. If a hospice pharmacy does not currently have E1 capability, instructions for getting set up are available on the CMS Part D Transaction Facilitator Web site at <http://medifacd.relayhealth.com/e1/getting-setup>.

Q20: To whom should hospices communicate information about an enrollee's unrelated drugs?

A20: Hospice providers should communicate information about an enrollee's unrelated prescription drugs to the enrollee's Part D plan sponsor. This communication may be initiated prior to the submission of a claim to Part D at the time of the hospice election or may occur following the sponsor's rejection of a claim either prior to a coverage determination request or when the Part D sponsor contacts the hospice in response to a beneficiary coverage determination request. Contact information for the Part D sponsors' customer service representatives is available on the CMS website at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDContacts.html>. The list includes the plan's marketing name, which can be used to search the list if the contract number is unknown.

Hospice providers may also provide written documentation of a beneficiary's hospice election, election revocation, or hospice discharge/termination to the beneficiary or pharmacy, or written information regarding unrelated medications to the beneficiary or pharmacy for subsequent reporting to the Part D sponsor.

Q21: Are all the drugs in the four categories identified in the July 18, 2014 memorandum considered related and, therefore, covered under the hospice benefit? Are all maintenance drugs considered unrelated and, therefore, covered under Part D?

A21: We expect the drugs in the four categories identified in the guidance memorandum (analgesics, antiemetics, laxatives, or antianxiety drugs) will routinely be provided by Medicare hospice providers as reasonable and necessary for the palliation and management of a beneficiary's terminal illness and related conditions. However, the hospice provider in assessing the beneficiary's medication needs may determine that a drug in the four categories is unrelated. As a result, that drug as well as all drugs outside the four categories, whether maintenance drugs or not, would be coverable under Part D if they otherwise meet the definition of a Part D drug.

Q22: What documentation of unrelatedness should a sponsor retain?

A22: Whether the sponsor receives the information stating a drug is unrelated to the terminal illness and/or related conditions in writing on a PA form or the sponsor completes the PA form based on

the information received verbally from the hospice or the prescriber, the PA form should be retained as documentation that the drug is unrelated and is, therefore, coverable under Part D.

Q23: When does Part D coverage for related drugs begin following the termination of the hospice benefit? The MA manual indicates Part C coverage starts the first of the month following termination of the hospice benefit and until then, services are paid by the Medicare Administrative Contractor under fee-for-service.

A23: Unlike the Medicare Advantage program, there is no alternative access to Part D drugs under Medicare fee-for-service. Thus, effective with the date of termination of the Medicare hospice benefit due to revocation, discharge or other termination, all Part D drugs, including those related to the terminal illness and related conditions, are coverable under the member's Part D benefit.

Q24: Per Chapter 18 of the Medicare Prescription Drug Benefit Manual, tolling is not allowed for PA requests. Is tolling allowed for these beneficiary-level hospice PAs?

A24: For purposes of the coordination of benefits processes outlined in the July 18, 2014 memorandum, we believe it is appropriate to apply the processing timeframes applicable to exception requests as described in section 30.2 of Chapter 18 of the *Medicare Prescription Drug Benefit Manual* to coverage determination requests that involve the beneficiary-level hospice PA. In other words, the applicable adjudication timeframe of 24 hours (for expedited requests) or 72 hours (for standard requests) begins when a statement that the drug is unrelated to the terminal illness or related conditions is received from the Medicare hospice provider or prescriber.

In accordance with existing guidance on processing timeframes for exception requests, a plan sponsor must not keep the request open indefinitely; while the adjudication timeframe may be tolled pending receipt of the necessary information, the start of the adjudication timeframe can only be tolled for a reasonable period of time based on the facts and circumstances of the case. Further, for coverage determination requests that also involve an exception to a drug-specific UM requirement, the adjudication timeframe can only be tolled once consistent with the above-stated expectation that the beneficiary-level hospice PA and the drug-specific UM requirement be considered concurrently.

Q25: Must a sponsor verify that a prescriber is affiliated with the hospice? If the prescriber is unaffiliated, may the sponsor accept a verbal attestation that the prescriber has conferred with the hospice?

A25: No, a sponsor need not verify that a prescriber is affiliated with the hospice. If during the PA process, the sponsor determines that the prescriber is unaffiliated with the hospice, the sponsor should secure confirmation that the prescriber has conferred with the hospice provider and the hospice agrees the drug is unrelated. This attestation may be verbal or written and should be documented on the PA form and retained to support the sponsor's coverage of the drug under Part D.

Q26: When a claim is retrospectively determined to be a hospice or beneficiary liability, should the PDE be deleted or adjusted to zero dollars?

A26: When payment is retrospectively determined to be the responsibility of the hospice provider or the beneficiary, the sponsor must delete the PDE for the claim because the drug does not meet the definition of a covered Part D drug. The sponsor must also remove the costs from the member's TrOOP and gross covered drug costs.

Q27: If a claim is retrospectively determined to be a member liability and the sponsor collects from the beneficiary, must the sponsor request the pharmacy reverse the claim and/or delete the PDE?

A27: Beneficiaries will be responsible for drugs related to the terminal illness and/or related conditions, but waived through the beneficiary's hospice election or unavailable through the hospice due, for example, to the imposition of the hospice's formulary requirements or the hospice's determination that the drug is not medically necessary. Since the drugs are related, they are not coverable under Part D and the PDE must be deleted. However, once the Part D sponsor has recovered the erroneous payment from the beneficiary, there is no need to request the pharmacy reverse the claim.

Q28: Since no independent review entity (IRE) is available, does this mean beneficiaries are unable to appeal?

A28: Although no IRE is available to resolve payer vs. payer disputes when the Part D sponsor disagrees with the hospice provider's or prescriber's statement that the drug is unrelated, this absence does not affect the beneficiary's appeal rights under either Part A or Part D. Beneficiaries retain the right to appeal Part A coverage decisions through the Medicare fee-for-service process and Part D coverage decisions through the Part D appeals process.

Q29: Although CMS encourages sponsors to employ a single-use PA form for the beneficiary-level hospice PAs, is it acceptable for sponsors to use a general PA form when other utilization management PAs are required?

A29: Although we recognize there will be instances when other utilization management requirements must be satisfied in addition to the beneficiary-specific hospice PA edit, we do not believe this will occur at a frequency sufficient to warrant general use of a single multi-purpose PA form. Thus, for simplicity we encourage sponsors to use the first page of the CMS-edited NCPDP form for reporting information to override a Part D hospice PA edit that accompanied the July 18, 2014 memorandum.

Q30: Does the guidance apply to Medicare Advantage-Prescription Drug (MA-PD) plans as well as stand-alone Prescription Drug Plans (PDPs)?

A30: The revised Part D hospice guidance issued July 18, 2014 and titled, "Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice," applies to all sponsors of Medicare Part D benefit plans. This would include plans such as MA-PDs, PDPs, and Medicare-Medicaid plans (MMPs).

Q31: Do the beneficiary-level hospice PA edits apply to Medicare/Medicaid dual eligible?

A31: The beneficiary-specific hospice PA edits apply to all Medicare Part D enrollees who are in a hospice election period as of the date the prescription is submitted for filling. These PA edits are necessary to determine whether or not a drug in the four categories is related to the beneficiary's terminal illness and/or related conditions and, therefore, covered under the Part A hospice benefit. A beneficiary's dual Medicare and Medicaid eligibility is irrelevant to the determination of whether a drug is covered under the Part A hospice benefit or may be covered under Part D.

Q32: Why are Part D sponsors imposing the requirements prior to October 1, 2014?

A32: As stated in the memorandum of July 18, 2014, the revised guidance was effective upon issuance, but we recognize the time sponsors will require to implement the changes to effectuate the guidance will vary. Thus, we encourage sponsors to implement the as soon as possible, but no later than October 1st.