**Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals)**

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**Description:** Provides the CCR with details necessary to assist a beneficiary with questions regarding a **new request** or **status update** for a Med D Coverage Determination or Redetermination, prescription cost, non-formulary medications, tiering exceptions, or prior authorizations and provide the appropriate resources to contact based on the beneficiary’s request.

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| Important Information |

Refer to the Coverage Determination section of the plan’s CIF to determine if Coverage Determinations & Appeals are handled by CVS Caremark or the Client.



* Coverage Determinations details may also be found in Compass from the **Benefits** tab on the **Clients Specifics** sub-tab.

Although a MED D plan has a specific formulary of covered medications, MED D beneficiaries can ask the plan to cover medications not included on the formulary or drugs that are on the formulary but have predetermined criteria.

* These initial requests are called Coverage Determinations.

If a beneficiary disagrees with the plan's decision, there are five (5) levels of appeals available to try to obtain coverage of medications.

* However, PBMs handle only the first level of appeals, also known as a Redetermination.

 Refer to the CIF for direction on the proper team to assist with CD&A questions.

**Notes:**

* Do NOT proactively offer Tiering or Formulary Exceptions unless otherwise directed in the document.
* There may be two lines of eligibility visible for migrating plans and in some cases, a transfer to a different Customer Care group may be required. Check the CIF for the correct process.

 Unless otherwise noted, all phone numbers provided throughout the document are **internal only and should not** be provided to callers.

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| Appeals Overview |

 Information regarding Appeals—**including the phone number for C2C, IRE, etcetera**—can ONLY be provided to the beneficiary by the CD&A team because appeals requests may require a clinical review. During business hours, Customer Care will warm transfer beneficiary to the Coverage Determination department at (877-827-7315 opt 2). If after hours, contact the Senior Team and a Senior will send an email to 8556337673@fax.cvshealth.com for the request.

An Appeal is a request by an enrollee, the enrollee’s representative, or the enrollee’s provider (if allowed by law) to review a denied Coverage Determination made by the Part D plan sponsor on the benefits under a Part D plan the enrollee believes he or she is entitled to receive or on any amounts the enrollee must pay for the drug coverage.

There are five (5) successive levels of appeals in the Medicare Part D program:

1. Redetermination
   * Reviewed by CVS Caremark or Client (dependent upon whether the Client delegates Redeterminations to CVS Caremark)
2. Reconsideration
   * Reviewed by an Independent Review Entity (IRE)
3. Administrative Law Judge (ALJ)
   * Reviewed by a law judge
4. Medicare Appeals Council (MAC)
5. Judicial Review
   * Reviewed by a Federal District Court

**Note:** To educate the beneficiary or provide information on the Appeals Process, transfer to the Senior Escalation Team.

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| Provider Calls |

Proceed depending on what the provider is calling for:

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| **If the provider is calling for…** | **Then…** |
| * Formulary alternatives for a non-formulary medication * Lower cost alternatives for a formulary medication | Proceed to the **Process** section of [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). |
| A Coverage Determination or Appeal | Warm transfer to **1-877-827-7315 and select prompt 2**.  **Notes:**   * Do not provide the above telephone numbers to a beneficiary. They are for provider calls only. For beneficiary calls, refer to the [Decision Grid](#_CCR_Checklist) section. * For CD&A hours of operation, refer to [Phone Numbers (Contacts, Departments, Directory, Addresses, Hours and Programs) (004378)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f22eb77e-4033-4ad9-9afb-fc262f29faad). * If after hours, Customer Care must submit a Coverage Determination request. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). |

**Note:** If the beneficiary is calling to advise of a new provider or prescriber for an in-process CD request, transfer to the Senior Escalation Team.

**Reminder:** Refer to [HIPAA (Health Insurance Portability and Accountability Act) Grid - CVS (028920)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5b354e50-0d15-42d0-b9c2-0711ea02d9ce) to ensure prescriber/provider guidelines are followed.

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| Authorized Persons Who Can Start or Check the Status of a Coverage Determination or Redetermination |

 Before beginning the process or checking the status of a Coverage Determination or Redetermination, the CCRs **MUST** verify they are speaking to one of the following individuals:

* Beneficiary
* Authenticated SHIP Counselor
* Physician or other Prescriber (includes representative of a prescriber's office or a representative of the prescriber)
* Power of Attorney (POA) or Appointed Representative (AOR)
  + Legal Documentation MUST be viewable in Compass or FACETS to continue with the caller's request.
* Pharmacy
  + The pharmacy can check the status of a Coverage Determination or Redetermination.

If third-party is not authorized:

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| **Scenario** | **Action** |
| The beneficiary is present and has authorized the third-party to speak on their behalf. | Any CD/Appeal would be handled in the same way it would be if speaking to the beneficiary (see [Process](#_Decision_Grid) below). |
| The beneficiary is not present and/or third-party is not AOR or POA. | Educate the third-party that only the beneficiary has the right to file a CD/RD unless the third-party is an AOR or POA on the account. If no AOR/POA on file, offer to send form to third-party.  Refer to the Identify Caller screen for POA document address/fax number, as well as instructions on sending an AOR form.   * A caller that is not authorized with either verbal consent or a POA/AOR on file can submit a CDA if they insist. Select the **Caller insists on a coverage determination** checkbox on the Identify Caller screen. |

Refer to [Compass MED D - Appointed Representative Form (AOR) or Power of Attorney (POA) (061884)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=64c3fc62-48c3-4ad3-ae83-c736cebd521b).

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| Decision Grid |

The following is a snapshot of all the steps and decisions the CCR should consider that are outlined in the Decision Grid. This is NOT an all-inclusive list and must be used in combination with the [Process](#_Decision_Grid).

Run Test Claim to identify type of coverage determination request (rejection):

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| --- | --- | --- |
| **Scenario** | **Description Example** | **Action** |
| **Redetermination (Appeals)** | Based on CMS guidelines, the beneficiary can submit a redetermination for any reject. | To submit a redetermination, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). |
| **Excluded by Med-D Law (Reject A5)** | Not Covered Under Part D Law | Refer to [Drug excluded by Part D Law](#MEDDLAW) in Process Step 9. |
| **Tiering Exception** | No reject code will display | **SilverScript PDP Members ONLY:** Drug on [Med D - Tiering Exception Exclusions - No Preferred Alternatives (010234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=90c3c22e-86f7-46a9-934a-d5b17c67227d): CCR educates the caller.  Member in Catastrophic Stage: Educate the caller.  To submit a tiering exception, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). |
| **Non-Formulary (Reject 70)** | * Reject 70 displays as NDC Product/Service Not Covered Pending Formulary Review. * 70 Non-Formulary Drug, Contact Prescriber * 70 NDC Not Covered * NDC/Product/Service not covered. Use \_\_or EXC. Non-Formulary Drug, Contact Prescriber | To submit a formulary exception, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). |
| **Prior Authorization (Reject 75)** | PA REQ CALL x-xxx-xxx-xxxx  Messaging can vary based on the plan. | To submit a Prior Authorization, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). |
| **Quantity Limit Exception (Reject 76)** | * Plan Limitations Exceeded * QTY LIMIT EXCEEDED PA REQ’D XXX-XXX-XXXX | To submit a quantity limit exception, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4).  Reject AG (Days’ Supply Limitation for Product/Service) seems the same as Reject 76, but the rejections are **NOT** the same. **DO NOT** use this step if Reject Code AG is given. |
| **Reject 76 and Reject 19**  **(Day Supply Limitation)** | * Plan Limitations Exceeded, MI/ Days’ Supply or   “PA-Required-MD Contact CVS Caremark”, “Maximum Days Supply of 90” or “Maximum Days’ Supply of 30” | Review the Day Supply on the claim. Modify the test claim to match the allowed days supply and re-run the test claim. Then refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4).  **Example:** If original claim was submitted as 100/100 days, then re-process the test claim for 90/90 days. |
| **Step Therapy Exception (Reject 608 or Reject 75 AND 76 with reject messaging "Must Meet Step")** | Reject 608 - Step Therapy, Alternate Drug Therapy Required Prior To Use of Submitted Product Service ID | To submit a step therapy exception, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). |

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| Process |

 Only file a First Call Resolution Grievance for plan design issues or for issues with the Coverage Determination process.

**CCRs will handle all calls as normal that are associated with the Catastrophic Stage, Inquiry, or ANOC issues.**

For the scenarios listed - MED D prescription cost, non-formulary medication, prior authorization,or a pending request update, the CCR will:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Step** | **Action** | | | | | | | | | |
| **1** | One moment while I access your profile and review the status of your prescriptions. | | | | | | | | | |
| **2** | Refer to the appropriate CIF to determine who handles Coverage Determinations for the plan. | | | | | | | | | |
| **If…** | **Then…** | | | | | | | | |
| CVS Handles | Proceed to [Step 3](#DecisionGrid3). | | | | | | | | |
| Client Handles | Proceed using the process outlined in the CIF. DO NOT create a Med D CD&A Support Task. | | | | | | | | |
| **3** | Determine if the beneficiary is in the Catastrophic Stage. Refer to [Compass MED D - Determining TrOOP Status and Viewing Accumulations (061776)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a9b488ea-c09d-417f-91f4-cb785b4eb6ad).  **Note:** If the call is disconnected and a Coverage Determination had been discussed, the representative should make 1 attempt to call the beneficiary back. Refer to [Disconnected, Dropped, No Caller (Ghost Calls), Spam, Automated, and Looping Calls (021760)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=480af287-dcb8-4305-84c5-dfe8e0c39312). If unable to reach the beneficiary, submit a request following [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). | | | | | | | | | |
| **If the beneficiary is…** | **Then…** | | | | | | | | |
| In the Catastrophic Stage | * Beneficiaries in these stages need to be notified and educated by the CCR.   I see that you are currently in the < Catastrophic Stage>. Let me tell you about the < Catastrophic Stage> and how it impacts you.   * Proceed to the next step.   **Notes:**   * If the beneficiary wants to find lower cost alternative medications, run a Test Claim and view Alternatives. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b). * If the beneficiary states that they need a lower cost or asks for a Tiering Exception, confirm if the specific plan provides **enhanced benefits**.   + If no, run a Test Claim and view Alternatives. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b).   + If yes, submit a Tiering Exception from the test claim results. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). | | | | | | | | |
| Not in the Catastrophic Stage | Proceed to the next step. | | | | | | | | |
| **4** | Determine if a CD&A case is in process or has been completed by selecting the **Override/PA History** hyperlink in the **Quick Actions** panel on the Claims Landing Page. | | | | | | | | | |
| **If...** | **Then...** | | | | | | | | |
| Yes | Proceed to [Step 5](#DecisionGrid5). | | | | | | | | |
| No | Skip to [Step 7](#DecisionGrid7). | | | | | | | | |
| **5** | Click the **ID** hyperlink the specific PA/Coverage Determination line in question in the **PA Status** section for the Prior Authorization or Appeal to review. | | | | | | | | | |
| **6** | **Result:** The details, including (but not limited to) the **Status Description** and **Reason** will populate at the bottom of the screen.  **Note:** In the **PA Status** section, the **Approval Thru** date may be incorrect. Always refer to the **Override History** section to ensure that the correct expiration date of the override is provided.    **Note:** A resolved Grievance should be filed **only** if the beneficiary is upset about the **Coverage Determination process**.  **Note:** Decision letters can only be resent to the prescriber or beneficiary. If a beneficiary is asking for a CD&A case decision letter to be resent or has a special request regarding their letter font or language during business hours, Customer Care will contact the Coverage Determination department at (877-827-7315 opt 2) to request the decision letter is resent. If after hours, contact the Senior Team and a Senior will send an email to 8556337673@fax.cvshealth.com for the request. | | | | | | | | | |
| **If** **Status is…** | **Then…** | | | | | | | | |
| Closed **and** Resolution: Approved | Advise the beneficiary of the approval and next steps.    The Prior Authorization for <medication name> has been approved for <provide number of months> as of <effective date>. The medication will now process through the prescription benefit coverage. Please remember to ask the prescriber to renew the Prior Authorization again before <provide expiration date>.  Check for open orders under the **Mail Order History** tab. If there is an open order:   * Proceed to assist the beneficiary in processing their order. * Advise the beneficiary of the approval dates and TAT for the order.   Check for rejected claims under the **Claims** tab. If there is a rejected claim:   * Ask the beneficiary if any claims have been paid out of pocket.   + If a claim has been paid out of pocket, educate the beneficiary on submitting a paper claim. Refer to [Compass MED D - Researching and Submitting Paper Claims (061799)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=59458286-c3a2-4924-9f92-7a55cb5defb9) or, if it has been 7 days or less, offer to reach out to the pharmacy on the beneficiary’s behalf to reprocess the claim. * Advise the beneficiary that they will need to contact the retail pharmacy to reprocess the prescription claim with the current date (or the date the Prior Authorization was approved).   + If the beneficiary requests that the CCR perform the outreach, place the beneficiary on hold to make the outbound call to the pharmacy. If the beneficiary cannot hold, any outbound calls will need to be approved by your Supervisor.   **Notes:**   * A beneficiary may initiate a Coverage Determination or Redetermination renewal 90 days prior to it expiring. * A non-formulary medication that has been approved will not be eligible for a tiering exception. * Automatic PA extensions may be granted for a through date of next year (2023). This will be indicated in the **Notes and Attachments,** accessed by clicking the **ID** in Override History section. | | | | | | | | |
| Pending **or**  Resolution: In Process or Pending (including "ePA Pending Approval") | Review the member-facing notes and advise the beneficiary of the status.  **Example:** Waiting for the provider to respond to the need for additional documentation for the case.  Educate on expected timelines:  **Coverage Determination** requests can be either **standard** or **expedited**.   * **Standard Requests:** Decision within **72 hours** from date/time of receipt of valid request, but exception requests may be up to **408 hours** (17 days) if a statement of medical necessity is needed from the Prescriber.   + This includes nights, weekends and holidays. * **Expedited Requests:** Decision within **24 hours** from date/time of receipt of valid request, but exception requests may be up to **360 hours** (15 days) if a statement of medical necessity is needed from the Prescriber.   + This includes nights, weekends and holidays.   **Redetermination** requests can be either **standard** or **expedited**.   * **Standard Requests:** Decisions within **7 calendar days** from date/time of receipt of valid request.   + This includes nights, weekends and holidays. * **Expedited Requests:** Decisions within **72 hours** from date/time of receipt of valid request.   + This includes nights, weekends and holidays.   **CCR Notes:**   * If the request is standard and the beneficiary indicates they need the decision sooner than the expected timeline, create a new expedited Coverage Determination request. Submit a Coverage Determination request via Automation from test claim results, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). * If the beneficiary indicates they want to withdraw their open or pending request, transfer to the Senior Escalation Team. | | | | | | | | |
| Pending **or** Resolution: In Process or Pending (including ePA Pending Answer) | Review the member-facing notes and advise the beneficiary of the status.  **Example:** Waiting for the prescriber to provide the necessary information to initiate the case.   * Submit a Coverage Determination request via Automation from the test claim results, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4).   **CCR Notes:** ePA pending answer cases are requests started by the prescriber that have not been completed, so these cases are not yet valid. | | | | | | | | |
| Closed **and** Resolution: Cancelled | Advise beneficiary of dismissed Coverage Determination.   * Review the **Status Description and Reason** to determine why the Coverage Determination was dismissed. * The beneficiary can resubmit or appeal the dismissal.   + If the beneficiary can satisfy the request (i.e., provide missing information), it will go through the standard Coverage Determination process.   + Submit a new Coverage Determination request via Automation from test claim results if the beneficiary requests to resubmit or appeal. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4).   **Notes:** The Coverage Determination may still be denied after resubmitting or appealing the dismissal. At this point, the beneficiary would go through standard Redetermination process.  **CCR Note:** If member-oriented status states to contact CD&A, transfer to the Senior Escalation Team. | | | | | | | | |
| Closed **and** Resolution: Denied | The beneficiary may file a Redetermination request or 1st Level of the Appeal Process.   * Your plan allows you to request an appeal within 65 days of the denied Coverage Determination. * You can submit a new Coverage Determination for a review of this medication to reset your appeals options if more than 65 days have passed since the Coverage Determination was denied. | | | | | | | | |
| **If…** | | | **Then…** | | | | | |
| * Non-Formulary * Tiering Exception | | | Education the beneficiary on the denial using the **Status Description** via the **ID** hyperlink in the PA Status section, accessed through the **Override/PA History** hyperlink. **DO NOT** read the **Notes**; this is Clinical verbiage.  Your case was denied, and you will receive a letter that explains the reason for the denial and the next steps for appeal. | | | | | |
| **If beneficiary…** | | | **Then…** | | |
| Understands denial and is open to discussing alternatives  **OR**  Has questions regarding alternatives | | | Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b). | | |
|  |  |  | | | Is not accepting of alternatives and inquires about a lower price | | | Refer to [Compass MED D – Tiering Exceptions (075802)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=06496a6a-b4cc-44fa-9ace-293ec1547f77). | | |
|  |  |  | | | Has **SPECIFICALLY** stated that:   * They want to file a Redetermination. * They have already been through the process of alternatives (already spoke with MD and alternatives are not viable). * They have questions about the denial. | | | **Refer to** [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4)**.** | | |
| * Prior Authorization * Quantity Limit * Step Therapy | | | Educate the beneficiary on the denial using the **Status Description** via the **ID** hyperlink in the PA Status section, accessed through the **Override/PA History** hyperlink. **DO NOT** read the **Notes**; this is Clinical verbiage.    If the beneficiary has questions about the denial or wants to appeal the decision:  Your case was denied, and you will receive a letter that explains the reason for the denial and the next steps for appeal.  **If no:** Ensure that Beneficiary decisions and education are outlined in notes. Refer to [Compass - Close an Interaction or Research Case (050011)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b) and [Compass MED D - Call Documentation Job Aid (061758)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0).   * **If yes:** **Refer to** [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4) | | | | | |
| Denied Redetermination | | | If the beneficiary has questions about the denial or wants to appeal the decision:  Your appeal was denied, and you will receive a letter that explains the reason for the denial and the next steps for appeal.   * **If no:** Ensure that beneficiary decisions and education are outlined in notes. Refer to [Compass - Close an Interaction or Research Case (050011)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b) and [Compass MED D - Call Documentation Job Aid (061758)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0). * **If yes:** Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). | | | | | |
| **7** | * **SilverScript PDP Members ONLY:** Determine if the beneficiary is calling concerning the cost of a medication on the Tier Exception Exclusion List. Refer to  [Med D - Tiering Exception Exclusions - No Preferred Alternatives (010234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=90c3c22e-86f7-46a9-934a-d5b17c67227d). * **All other members:** Proceed to [Step 8](#DecisionGrid8). | | | | | | | | | |
| **If the SilverScript PDP beneficiary is concerned about cost of…** | | **Then…** | | | | | | | |
| A medication on the Tier Exception Exclusion List | | I'm sorry to inform you that this drug currently has No Preferred Alternatives and is not eligible to be moved to a lower tier or cost. It would be my pleasure to provide you with some information regarding financial assistance if you’d like. [Member Cannot Afford Medication (Alternatives and Financial Assistance) (026963)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=62aa67ac-8298-4fa1-b1ba-fda383d15b4c)   * If the beneficiary requests a Tiering Exception, submit a Tiering Exception via Automation from the test claim results. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). | | | | | | | |
| Another medication | | Proceed to [Step 8](#DecisionGrid8). | | | | | | | |
| **8** | Determine the type of MED D Prescription question the beneficiary is inquiring about:  To verify the tier of a formulary medication in question:   * **SSI:** Go to aetnamedicare.com to locate the formulary. * **EGWP:** Go to ONEclick to locate the formulary. * **NEJE:**   + For individual: Go to [www.RxMedicarePlans.com](http://www.RxMedicarePlans.com).   + For groups: Go to the [Plan Design Highlights section of the CIF (022305)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5744b311-00db-4c51-860c-32cdce740a68) and access the current year EGWP Matrix to view plan design and determine which formulary to view. Then go to <https://mydocumentsource.memberdoc.com/login> and provide the beneficiary’s ID # and zip code to locate the appropriate formulary. * **All Other Plans:** Locate the formulary in the CIF under the Plan Design Highlights section.   **DO NOT** use the **Formulary Tier** field on the **Drug** tab, in the **Claim Details** screen to determine the Tier of a medication.  If unable to locate the formulary, contact the Senior Team for assistance.  **Notes:**   * If at any time the beneficiary requests a lower cost for the medication, a Tiering Exception, or a Formulary Exception, submit a Coverage Determination Request via the test claims results. Proceed to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). * If at any time the beneficiary is requesting an escalation, warm transfer to the [Compass MED D - When to Transfer Calls to the Senior Team (062944)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0990aac5-274f-424d-9400-546d74b3fed7). | | | | | | | | | |
| **9** | Run a Test Claim to determine the type of Coverage Determination needed based on the type of Rejection.   * [Reject A5: Drug excluded by Med D Law](#MEDDLAW) * [Reject 70: Non-Formulary Issue](#REJECT70) * [No Reject Code: Concerns with Cost of Formulary Medication](#CostofForm) * [Reject 75: Prior Authorization](#Reject75) * [Reject 608 or Reject 75 AND Reject 76: Step Therapy](#StepTherapy) * [Reject 76: Quantity Limit Exception](#Reject76) * [Compounds](#Compounds) * [Specialty Medication](#Specialty) * [Reject A6: B vs D](#A6) * [Reject 88: Opioid](#Reject88) * [Paper Claim](#PaperClaimRequest)   **Note:** If a reject occurs on the primary and secondary plans, first follow the process outlined for the reject on the primary plan. | | | | | | | | | |
| **Scenario…** | | | **Action…** | | | | | | |
| Drug excluded by Part D Law  Reject A5  If Reject 70 displays with Reject A5, follow steps for Reject A5. | | | View **Additional Messages** field to determine if medication could potentially be covered under a different diagnosis. | | | | | | |
| **If…** | | **Then…** | | | | |
| Yes | | A message about a diagnosis exception potential will display in the **Additional Messages** section.  **Example:**    **Note:** Message response varies based on drug.   * Educate the beneficiary that the drug is excluded by Part D Law:   This drug is currently excluded by Medicare Part D Law. Your drug requires a review for coverage. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.   * Submit a formulary exception via automation from the test claim results and educate beneficiary. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4).   **Note:** If beneficiary is insisting on an Exception, **DO NOT** file a Grievance, and document actions in Compass. | | | | |
| No | | A message about a diagnosis exception potential will **not** display.     * Educate the beneficiary that the drug is excluded by Part D Law:   This drug is currently excluded by Medicare Part D Law. We will need to identify if there are any potential alternatives available to you.   * Check for alternatives and advise beneficiary of covered alternative.   + If none display, consult with clinical to confirm none available , and educate the member.     - If beneficiary does not want alternatives or is unhappy because there are no other alternatives, file a Resolved Grievance in MHK or Compass if dissatisfaction was expressed.       * **Documentation guidance:** The following needs to be documented in the Grievance file:   Educated beneficiary that this is a Med D excluded drug and none of the exceptions were requested by the beneficiary.  **Note:** If this is an **inquiry** only, do NOT file a grievance. | | | | |
| Non-Formulary medication  Reject 70  **Notes:**   * If Reject 70 displays with Reject A5, follow steps for Reject A5. * If Reject 76 displays with Reject 70, follow steps for Reject 70. * This also applies to a call related to an expired Non-Formulary exception. | | | Your drug is currently not included on your formulary. I can discuss alternatives and other options that might be available to you.  Submit a Formulary Exception via automation from the test claim results. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4)**.** | | | | | | |
| Concerns with Cost of Formulary Medication  Not associated with a rejected claim  This also applies to a call related to an expired Tiering Exception. | | | Determine if the beneficiary is in the Deductible, or Catastrophic Stage. Refer to [Compass MED D - Determining TrOOP Status and Viewing Accumulations (061776)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a9b488ea-c09d-417f-91f4-cb785b4eb6ad).   * If the beneficiary **IS** in the Deductible, or Catastrophic Stage, educate the beneficiary:  I see you are currently in the < Deductible OR Catastrophic Stage>. Let me explain what that means to you.   + Following the education, if the beneficiary insists on an Exception or a lower cost, proceed to the appropriate scenario below. * If the beneficiary **IS NOT** in the Deductible, or Catastrophic Stage, proceed to the appropriate scenario below.   **SilverScript PDP Members ONLY:** Determine if the beneficiary is calling concerning the cost of a medication on the Tier Exception Exclusion List. Refer to [Med D – Tier Exception Exclusions – No Preferred Alternatives (010234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=90c3c22e-86f7-46a9-934a-d5b17c67227d).   * If the medication **IS** on the Tier Exception Exclusion – No Preferred Alternatives list:   Educate the beneficiary:  I'm sorry to inform you that this drug currently has No Preferred Alternatives and is not eligible to be moved to a lower tier or cost. It would be my pleasure to provide you with some information regarding financial assistance if you'd like. [Member Cannot Afford Medication (Alternatives and Financial Assistance) (026963)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=62aa67ac-8298-4fa1-b1ba-fda383d15b4c)   * + If the beneficiary requests an Exception, submit a Tiering Exception via Automation from the test claim results. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). * If the medication **IS NOT** on the Tier Exception Exclusion - No Preferred Alternatives list, proceed to the appropriate scenario below.   **Notes:**   * Always check the CIF to determine if beneficiary's Plan Benefit Design will provide a lower cost with a Tiering Exception. Do not file a Tiering Exception for the following situations:   + A Specialty medication   + Lowest Cost Tier   + In the Deductible Stage (unless a Tiering Exception will lower the tier and the beneficiary will no longer have to pay the deductible cost) * **DO NOT** transfer for a Tiering Exception if a non-formulary approval is already on file for the beneficiary for the same drug.   Proceed depending on the appropriate scenario: | | | | | | |
| **Scenario** | | | **Action** | | | |
| Lowest Cost Tier  **Notes:**   * Validate Tier structure using formulary and/or CIF * For lowest cost tier medications, a Grievance Resolved should be filed in MHK or Compass due to dissatisfaction that the medication cost cannot be lowered. It is vital that the Grievance documentation indicates that it is for a lowest cost tier medication and does not qualify for an exception. | | | Educate the beneficiary on the Plan Benefit Design. This is the lowest cost copay.  In researching, I have identified your medication is currently at the lowest cost copay on the Plan. We will need to identify if there are any potential alternatives available to you. | | | |
| **If beneficiary…** | | | **Then…** |
| Is interested in alternatives | | | Review alternatives if displayed. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4).  If no alternatives are listed or member has clinical questions Transfer to the Clinical Care Services Team at **1-866-251-3591, Option 2**.    Please hold while I transfer you to our Clinical team to determine if there are any alternatives. |
| Does not want alternatives or is unhappy with no other options | | | File a Resolved Grievance in MHK or Compass. |
| Requests an Exception | | | Submit a Tiering Exception via Automation from the test claim results, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4).  **Note:** If the beneficiary requests an Exception, **DO NOT** file a Grievance. Document all actions taken in Compass. |
| Not Lowest Cost Tier, Not Specialty Tier | | | In researching, I have identified your medication is a tiered drug, so I will assist you in looking for alternatives and any other options available to you.  For next steps, proceed to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4) | | | |
| Beneficiary asks to lower the cost of a medication and they are enrolled in a 1-tier plan (Client specific) | | | Educate the beneficiary on the Plan Benefit Design.  In researching, I have identified your medication is currently at the lowest cost copay on the Plan. | | | |
| Specialty Tier Medication  **Note:** Specialty Medication (a medication that is on the [Caremark Specialty Drug List](https://www.caremark.com/wps/portal/!ut/p/c5/04_SB8K8xLLM9MSSzPy8xBz9CP0os3gnC3NzC-8gw1CXAB8DA08zY1cfD0MXYwM_c6B8pFm8AQ7gaIBPt4EBRLeje1hooIGzuZmBp7OJgadRWJi7r4eJoYG7GTF24zEdv24_j_zcVP2C3NDQiHJHRQDKE8oO/dl3/d3/L2dJQSEvUUt3QS9ZQnZ3LzZfQjg3NzhLUjFVRFBMMDBJNjNFTEgxRDMwVjY!/) or that Compass gives indication) does not necessarily mean it is a High Cost Specialty Tier. A Specialty medication may be on any Tier on the Plan formulary and may be eligible for a Tiering Exception.  For Specialty medication:   * Access the Plan's formulary document. * Determine the Tier. * Follow the appropriate process located within this grid for that Tier. | | | * Educate the beneficiary on the Plan Benefit Design. * Review alternatives with the beneficiary. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b).   **Notes:**   * Refer to the [Specialty Medications](#Specialty) scenario below for additional information. | | | |
| Prior Authorization  Reject 75 | | | Your drug requires a prior authorization. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.  Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4).- US702970 as needed. | | | | | | |
| Step Therapy Exception  Reject 608 or Reject 75 AND Reject 76 with reject messaging "Must Meet Step" | | | Your drug requires a step therapy exception. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.  Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4) as needed. | | | | | | |
| Quantity Limit Exception  Reject 76  If Reject 76 displays with Reject 70, follow steps for Reject 70.  Reject AG (Days Supply Limitation For Product/Service) may look similar to Reject 76 but are NOT the same. DO NOT use this step if Reject Code AG is given. | | | Your drug requires a quantity limit exception. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.  Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4) as needed. | | | | | | |
| Compounds  Reject 70 (and potentially others depending on ingredients) | | | Submit a Formulary Exception via Automation from the test claim results, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). Notate it is a Compound in the **Notes** section of the request.  **Note:** There are no alternatives; an RPh must review. | | | | | | |
| Specialty Medication | | | Determine the scenario:  **Exception:** Carefirst: Always warm transfer Specialty calls. | | | | | | |
| **Scenario…** | | | | | **Action…** | |
| Copay, Mail Order, General Questions | | | | | Conference in the Specialty Care team for assistance at 800-237-2767. | |
| Alternatives or Clinical Questions | | | | | Conference in the Specialty Pharmacist for assistance at 800-308-1977, Option 3, Option 2. | |
| If alternatives are not available and beneficiary requests a coverage determination | | | | | Submit a Coverage Determination request. Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). | |
| B vs. D Prior Authorization  Reject A6 | | | Your drug requires a prior authorization. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.  Refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4) as needed.  **Note:** Beneficiaries should refer to their Part B plan or have a conversation with their provider on how they are responding (Dx code) on the need for the medication before submitting a redetermination. This applies to redetermination only, not the first time the beneficiaries make a request for B vs D. | | | | | | |
| Opioid  Reject 88 PPSREQD | | | * Educate the beneficiary on options for the restrictions. Refer to [MED D - FAQs - Opioid Changes (Reject 925 and 88) (013567)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=ccd35909-9dbe-4add-8241-c10b6dc83109). * If beneficiary indicates they have received a letter stating they are potentially subject to this restriction, refer to [Compass MED D - Member Specific Utilization Management Edit (MSUME) (061920)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=6f2ee878-3069-4f28-b684-4818b3233ab5).   **Note:** Restrictions may be in place for one or more of the following:   * Day Supply * Pharmacy Lock * Prescriber Lock   Refer to [MED D - FAQs - Opioid Changes (Reject 925 and 88) (013567)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ccd35909-9dbe-4add-8241-c10b6dc83109) for guidance.  If beneficiary has received restrictions on opioids and would like to initiate a CD, refer to [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=dd008e39-837c-4493-9708-c98080c448f4). | | | | | | |
| Paper Claim Request  **Example:** Billed for a medication while receiving outpatient surgery | | | * Perform a fulfillment task to send a paper claim form. Refer to [Compass MED D - Researching and Submitting Paper Claims (061799)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=59458286-c3a2-4924-9f92-7a55cb5defb9). * Review the **Beneficiary Disputes Reimbursement Amount on Rx** section in [Compass MED D - Researching and Submitting Paper Claims (061799)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=59458286-c3a2-4924-9f92-7a55cb5defb9). * Educate beneficiary on reimbursement rate. | | | | | | |
| **10** | Ensure that the beneficiary response and education are documented in the notes. Refer to [Compass - Close an Interaction or Research Case (050011)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b) and [Compass MED D - Call Documentation Job Aid (061758)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0). | | | | | | | | | |
| **Scenario…** | | | **Required Documentation…** | | | | | | |
| Non-Formulary Drugs | | | Discussed alternatives. | | | | | | |
| Lowest Cost Tier Formulary Drugs | | | * Educated beneficiary <drug name> is on lowest cost tier of plan. * Beneficiary's response/action:   + Interested in alternatives: Discuss alternatives, if available.   **OR**   * + Declined alternatives/unhappy with no options: Filed a Resolved (First Call Resolution) Grievance. | | | | | | |
| Not Lowest Cost Tier, Not Specialty Tier Formulary  Drugs | | | Discussed alternatives. | | | | | | |
| Specialty Tier Formulary Drugs | | | Discussed alternatives. | | | | | | |
| * Quantity Limit * Step Therapy * Prior Authorization | | | Submitted a Coverage Determination Request. | | | | | | |

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| Submitting a Support Task for CD&A |

 **This process will only be available when the automation fails, and the CCR is unable to submit a Coverage Determination Request from the Test Claim Results screen.** When creating a **Support Task**, if **Med D – CD&A** is selected as the **Task Category Type** and Coverage Determinations & Appeals are **not** handled by CVS Caremark, the following message will appear: “Caremark is not delegated to handle Coverage Determinations & Appeals for this client. Follow the process in the CIF.”

May vary by client; always refer to the CIF.

**Note:** Review the **Member’s Recent Support Task** panel in the **Case Details** tab and the **Override/PA History** link to confirm a CD&A request is not already in process for the same medication.

 Each medication requested will require a separate Coverage Determination.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Step** | **Action** | | | |
| **1** | Determine which of the following apply while attempting to create a CD&A Support Task. | | | |
| **If…** | | **Then…** | |
| Caller **does not** want to initiate request now | | Proceed to [Step 2](#SubmittingStep2). | |
| Caller **does** want to initiate the request now | | Skip to [Step 3](#SubmittingStep3). | |
| **2** | Determine if the caller is the beneficiary (or beneficiary's representative) or is a Physician/other Prescriber. | | | |
| **If…** | | **Then…** | |
| **Start the request later** and is a **beneficiary** or **beneficiary's representative (AOR or POA is on file)** | | In order to make sure I understand correctly, you would like to wait and begin your request at a later time? | |
| **If…** | **Then…** |
| Yes | * I understand. * Please feel free to contact us at your earliest convenience 24 hours a day, 7 days a week. * You can find the number on the back of your ID card.   + **Process Note:** Look up the specific client Care number on the CIF. * Completed Coverage Determination forms can also be faxed or mailed to:   **Fax:**  MED D Coverage Determination and Appeals (CD&A)  Fax #: **1-855-633-7673**  **Mail:**  CVS Caremark Part D Services  Coverage Determinations & Appeals  P.O. Box 52000  MC109  Phoenix, AZ 85072-2000   * You may also utilize your plan's website, which contains a Coverage Determination request form and tells you how to submit the request electronically, if you prefer.   Skip to [Step 6](#SubmittingStep6). |
| No | I will be happy to send your request so that it can be reviewed by the Coverage Determination Department.  Proceed to [Step 3](#SubmittingStep3). |
| **Start the request later** and is a **Physician** or **other Prescriber** | | In order to make sure I understand correctly, you would like to wait and begin your request at a later time? | |
| **If…** | **Then…** |
| Yes | * I understand. * Please feel free to contact us at your earliest convenience. * You can contact MED D Coverage Determination and Appeals (CD&A) for Coverage Determination requests at **1-877-827-7315 and select prompt 2**.   **CCR Note:** Do not provide the above telephone numbers to a beneficiary. They are for provider and prescriber calls only.   * Completed Coverage Determination forms can also be faxed or mailed to:   **Fax:**  MED D Coverage Determination and Appeals (CD&A)  Fax #: **1-855-633-7673**  **Mail:**  CVS Caremark Part D Services  Coverage Determinations & Appeals  P.O. Box 52000  MC109  Phoenix, AZ 85072-2000   * You may also utilize the plan's website, which contains a Coverage Determination request form and tells you how to submit the request electronically, if you prefer.   Skip to [Step 6](#SubmittingStep6). |
| No | I will be happy to send your request so that it can be reviewed by the Coverage Determination Department.  Proceed to [Step 3](#SubmittingStep3). |
| **3** | Determine if the request is **standard** or **expedited**. Requests should always be labelled as **standard** unless the beneficiary or physician indicates the request should be expedited.  To determine if **expedited** task is needed, listen for the following phrases:   * Patient is out of medication. * Patient will be hospitalized or die if they do not receive the medication. * Need medication in 24 hours or today/tomorrow * Expedite * Urgent * Immediate * Stat * Emergency * Exigent   **Reminder:** Sending the task is considered an **Oral Request**. | | | |
| **If the request is…** | | **Then…** | |
| Standard | | Submit the following Support task:  Each medication requested will require a separate Support Task.  **Note:** If there is a rejected claim on the claims table, click on the Rx # and populate the Support Task through the **Claim Details** tab.  **Task Category Type:** Med D – CD&A  **Priority Field:** Select **Normal** if Standard  **Task Request Type:**   * For Coverage Determination: Standard Coverage Determination PA * For Redetermination: Standard Redetermination Appeal   **Select the appropriate CD&A Category and CD&A Type**  **REQUIRED Support Task Fields:**   * Contact Phone Number (Area Code – Phone - Extension) * Provider Name * Provider Phone Number (Area Code – Phone - Extension)   **You MUST ask the caller for Provider Name, Phone, and Fax Number and document them in the Support Task.** If the caller cannot provide at least the Provider Name and Phone Number, do not submit the Support Task. Advise the caller that we cannot proceed with the request.   * NDC, including Drug Name and Strength   **Notes Field:**  The following information is required:  **Provider Name, Phone, and Fax Number (if available).** If the caller cannot provide the Provider Name and Phone Number, we cannot proceed with the request.   * The oral request in writing **(in the** **requestor's own words**) * Medication Name, including NDC * Quantity and Day Supply for the medication * Reject Code for the medication. Refer to [Process](#_Decision_Grid).   **Tiering Exceptions do not have a reject code; notate if request is for Tiering.**  **Reminder:** Complete **ALL** required fields that are marked with an **asterisk (\*)**. Complete additional Support Task fields with information as provided.  Proceed to the next step. | |
| Expedited | | Submit the following Support Task:  Each medication requested will require a separate Support Task.  **Note:** If there is a rejected claim on the claims table, click on the Rx # and populate the Support Task through the Claim Details tab.  **Task Category Type:** Med D – CD&A  **Priority Field:** Select **Escalated** if Expedited  **Task Request Type:**   * For Coverage Determination: Expedited Coverage Determination PA * For Redetermination: Expedited Redetermination Appeal   **Select the appropriate CD&A Category and CD&A Type**  **REQUIRED Support Task Fields:**   * Contact Phone Number (Area Code – Phone - Extension) * Provider Name * Provider Phone Number (Area Code – Phone - Extension)   **You MUST ask the caller for Provider Name, Phone, and Fax Number and document them in the Support Task.** If the caller cannot provide at least the Provider Name and Phone Number, do not submit the Support Task. Advise the caller that we cannot proceed with the request.   * NDC, including Drug Name and Strength   **Notes Field:**  The following information is required:  **Provider Name, Phone, and Fax Number (if available).** If the caller cannot provide the Provider Name and Phone Number, we cannot proceed with the request.   * The oral request in writing **(in the requestor's own words**) * Medication Name, including NDC * Quantity and Day Supply for the medication * Reject Code for the medication. Refer to [Process](#_Decision_Grid).   **Tiering Exceptions do not have a reject code; notate if request is for Tiering.**  **Reminder:** Complete **ALL** required fields that are marked with an **asterisk (\*)**. Complete additional Support Task fields with information as provided.  Proceed to the next step. | |
| **4** | Repeat the entire request back to the caller to confirm accuracy.  This is a **mandatory** step and is **required** to be performed.  **Note:** If the call is disconnected and a Coverage Determination had been discussed, the representative should make 1 attempt to call the beneficiary back. Refer to [Disconnected, Dropped, No Caller (Ghost Calls), Spam, Automated, and Looping Calls (021760)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=480af287-dcb8-4305-84c5-dfe8e0c39312). If unable to reach the beneficiary, a Support Task should be submitted. | | | |
| **5** | Submit the Support Task, then advise the caller that:   * The request has been sent to the MED D Coverage Determination and Appeals (CD&A) Team. * The **beneficiary or beneficiary's representative** will be notified of the decision by an automated phone call (if valid phone number is on file) and/or a letter in the mail. * The **provider** will be notified by a fax and/or a letter in the mail.   **Process Notes:**   * Verify that an accurate phone number is on file and process an update if necessary.   + Refer to [Compass MED D - Address Changes and Out of Area (OOA) (061760)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a5cf7af0-8a89-45dc-a395-9961dceac183). * Close the Task by clicking the **X** on the Task tab.   **Do not** click the Mark Status as Complete button or change the status of the task.  The time frames to complete the **Coverage Determination** process are:   * **Standard:** Up to **72 hours** from date/time of receipt of valid request, but exception requests may be up to **408 hours** (17 days) if a statement of medical necessity is needed from the Provider.   + This includes nights, weekends, and holidays. * **Expedited:** Up to **24 hours** from date/time of receipt of valid request, but exception requests may be up to **360 hours** (15 days) if a statement of medical necessity is needed from the Provider.   + This includes nights, weekends, and holidays.   The time frames to complete the **Redetermination** process are:   * **Standard Requests:** Decisions within **7 calendar days** from date/time of receipt of valid request.   + This includes nights, weekends, and holidays. * **Expedited Requests:** Decisions within **72 hours** from date/time of receipt of valid request.   This includes nights, weekends, and holidays. | | | |
| **6** | Ask if there are any other benefit questions. | | | |
| **If…** | **If…** | | |
| Yes | * Address any benefit issues. * Document and close the call according to existing policies and procedures.   **Note:** Refer to [Compass - Close an Interaction or Research Case (050011)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b) and [Compass MED D - Call Documentation Job Aid (061758)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0). | | |
| No | Document and close the call according to existing policies and procedures.  **Reminder:** Document when a caller declines initiating a Coverage Determination.  **Note:** Refer to [Compass - Close an Interaction or Research Case (050011)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b) and [Compass MED D - Call Documentation Job Aid (061758)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0). | | |

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| FAQs |

Refer to the table below:

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| **#** | **Question** | **Answer** |
| **1** | **What is a Prior Authorization and why is the plan requesting one?** | For certain prescription drugs, the beneficiary needs to get approval from the plan before the plan will agree to cover the drug. In order to start the review process, the beneficiary or their prescriber must submit a Prior Authorization (PA) request. Drugs that require a PA are listed on the Formulary. This process is not intended to cause inconvenience, but rather to ensure medications receive the highest in safety and quality monitoring. It is not necessary to have a prescription on file to initiate a request for a formulary or non-formulary medication requiring a PA. |
| **2** | **Does a beneficiary need a prescription on file to process a Coverage Determination?** | No, a prescription does not determine or affect if a medication is covered by the plan. A prescription is needed to receive the medication from the pharmacy, but not to review a coverage determination. |
| **3** | **What about clients that handle their own CDAs. Will we continue to send to the plan or will the CCR initiate the Coverage Determination process?** | Any client that handles their own CDs would have the call transferred directly to them. The CCR would not initiate a Coverage Determination from a Test Claim or utilize the CD&A Support Task. |
| **4** | **In instances where beneficiary states dissatisfaction/concern about the price of a medication that is not on the lowest Tier or a Specialty Tier, would the CCR initiate the Coverage Determination process?** | Yes, the CCR should initiate the Coverage Determination process. Do not file a Grievance unless concerning the CD process, for example, amount of time for a decision to be made, speed of transfer, etc. |
| **5** | **What do I do if a medication rejects 70 and 76?** | Refer to the document above and follow the steps for reject 70. |

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| Related Documents |

* [Compass MED D - Initiate Coverage Determinations from Test Claim Results (064996)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=dd008e39-837c-4493-9708-c98080c448f4)
* [MED D - Appointment of Representative (AOR) form (096099)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=577a556f-330c-4ea1-b1c6-200d85b736cf)
* [Medicare Prescription Drug Coverage and Your Rights (018576)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ca887eaf-6d6b-4d2a-be9e-90d80b1c77cb)
* [MED D - Grievance vs. Coverage Determination – Decision Matrix (027480)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=06e8f82d-e7b7-4a60-9c81-3bf7c37aadbf)
* [MED D - Coverage Determination Requests for 2025 (069924)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2c7ceccc-bde6-4ec4-87d8-de77a64c7697)

**Parent Document:** CALL-0048: [Medicare Part D Customer Care Call Center Requirements-CVS Caremark Part D Services, L.L.C.](https://policy.corp.cvscaremark.com/pnp/faces/DocRenderer?documentId=CALL-0048)

**Abbreviations/Definitions:** [Customer Care Abbreviations, Definitions, and Terms Index (017428)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c1f1028b-e42c-4b4f-a4cf-cc0b42c91606)

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