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**Description:** Provides comprehensive templates for documenting grievances in Compass and capturing the reason, action, and result for First Call Resolution. The templates can also be used in PeopleSafe.

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| **Reminders** |

 **DO NOT** use this unless you have been trained on [Compass MED D - How to File a Grievance in Compass for Health Plans, JE](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81).

**These templates:**

* Should be used **only** for documentation.
* Provide key points to summarize and address with the member. **Do not** read the templates word for word to the member.
* Will assist in capturing the Reason, Action, and Result for First Call Resolution Grievances.
* Are **only** to be used for First Call Resolution Grievances in Compass.
* Do not cover all of the possible First Call Resolution Grievance types. If a CCR receives a call from a member who displays dissatisfaction and the First Call Resolution Grievance category is not listed, the CCR will continue to file the First Call Resolution Grievance providing the Reason, Action, and Result in their own words.
* Are intended to be a guide. If additional details are necessary to fully understand the member’s dissatisfaction and the resolution, be sure to add to the documentation. Failure to provide adequate details can result in grievance errors.
* Do not add verbiage unrelated to the grievance or the resolution.
* Compass Case Comments should be different from the grievance Description of Issue. Refer to [Compass - Call Documentation](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b) and [Compass MED D - Call Documentation Job Aid](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0).

Make sure to read the **RED BOLDED CAPITALIZED TEXT** information. Within each template, there may be Member-specific information that should be obtained prior to completing documentation.

http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png **Remove all special characters and bullet points from your notes**. Only periods and commas are permitted.

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| **BENEFITS** |

Refer to [Compass MED D - How to File a Grievance in Compass for Health Plans, JE](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) for further information.

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| **Copay Dissatisfaction (BENEFITS)** |

**REASON** The member expressed dissatisfaction that the plan copays are too high.

**ACTION** The Plan provided the member with access to their Plan materials which included a Formulary list of covered drugs, Pharmacy Directory or Pharmacy and the Evidence of Coverage booklet. The Formulary informs the member of which drugs are covered and their tier levels. The plan has different copays and coinsurances based on the tier level of each medication and stage of coverage that the member is in; the Plan informed the member this information was included in their EOC, What you pay for your Part D prescription drugs. The formulary and EOC are also available on the Plans website.

With healthcare costs continuing to rise, the Plan remains committed to providing ways to reduce prescription drug costs for our members. The Plan carefully reviewed our copay or coinsurance amounts to provide the most cost-effective plan design.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan encouraged the member to utilize a preferred pharmacy or the mail service pharmacy to lower the costs of their medications. The Plan also advised the member to discuss lower cost alternatives with their prescriber.

The Plan provided Extra Help information and encouraged the member to contact the Social Security Administration at 1.800.772.1213. Medicare could help pay a portion of their drug costs including monthly prescription drug premiums, annual deductibles, and copays. The member can also apply for Extra Help online at the Prescription Help section of www.socialsecurity.gov.

**IF STATE PHARMACY ASSISTANCE PROGRAM INFORMATION WAS PROVIDED, INCLUDE:**

The Plan advised the member of the State Pharmacy Assistance Program available in their state.

**If applicable, include:**

**MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| **No Savings through Mail Service Pharmacy (BENEFITS)** |

**REASON** The member is dissatisfied that there are no savings by filling prescriptions through the CVS Mail Service Pharmacy versus the retail pharmacy.

**ACTION** The member was informed that the mail service pharmacy is considered a preferred pharmacy which has agreed to offer preferred cost sharing, lower copays and coinsurance, for covered drugs. The mail service pharmacy provides the member with the convenience of having their prescription drugs delivered to their door at no extra cost. The member can also place orders for 90 day supplies of common maintenance drugs 24 hours a day, 7 days a week.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. Although it may seem as though the mail service pharmacy is not assisting the member with lower copays compared to retail, they are still receiving benefits and discounts as a member of the Plan.

**If applicable, include:A TIER EXCEPTION REQUEST WAS SUBMITTED.**

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| **LIS Cost Increase Due to Level Change (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their Low Income Subsidy, also known as Extra Help, cost has increased.

**ACTION** Plan records show the member was previously eligible for LIS Level **NUMBER**. At this time, the member is eligible for LIS Level **NUMBER**.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan has confirmed the member claims have adjudicated correctly based on their current LIS Level. The member was advised that they may contact Social Security at 1.800.772.1213 in regards to reevaluating their LIS level.

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| **LIS Cost Increase Due to New Year and Previously in Catastrophic Stage (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their Low Income Subsidy, also known as Extra Help, cost has increased.

**ACTION** Plan records show the member is eligible for LIS Level **NUMBER**.

The Plan has confirmed the member transitioned into the Catastrophic Coverage Stage last year in which they were responsible for a 0.00 dollar copay for all covered drugs for the remainder of the plan year. The member was advised that coverage stages are reset each plan year.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The member is no longer in the Catastrophic Coverage Stage as it is now a new year. During the Initial Coverage Phase they are responsible for the LIS standard copays or coinsurance or the Plans non LIS cost, whichever is less. Once the amount the member and Medicare pay as the Extra Help reaches 2,000 dollars in the 2025 Plan year, the member will be responsible for a 0.00 dollar copay for all covered drugs for the remainder of the plan year.

As of **DATE**, the member has **AMOUNT** remaining to reach the Catastrophic Coverage Stage.

The Plan has confirmed the member claims have adjudicated correctly based on their current LIS Level. The member was advised that they may contact Social Security at 1.800.772.1213 in regards to reevaluating their LIS level.

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| **Overall Plan Design Dissatisfaction (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png REMINDER:** DO NOT USE THIS TEMPLATE IF THERE IS A MORE SPECIFIC TEMPLATE AVAILABLE FOR THE MEMBER'S ISSUE. THIS TEMPLATE SHOULD ONLY BE USED FOR GENERAL (NON-DRUG SPECIFIC) PLAN DESIGN DISSATISFACTION.

**REASON** The member expressed dissatisfaction with the plan design.

**ACTION** The Plan materials were sent to the member, which provided important plan information.

With healthcare costs continuing to rise, the Plan remains committed to providing ways to reduce prescription drug costs for our members. The Plan carefully reviewed our copay coinsurance amounts, premiums and formulary to provide the most cost effective plan design.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan advised the member that they can obtain the most current plan information on the plans website. Additionally Customer Care is available 24 hours, 7 days a week to answer any questions they may have regarding their plan design.

The Plan explained to the member that Medicare limits when changes can be made to Medicare Part D coverage. The Annual Enrollment Period is from October 15th through December 7th of each year. During the AEP the member should review the ANOC to ensure the plan is a good fit for the upcoming plan year.

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| **Tier Change Dissatisfaction (BENEFITS)** |

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**REASON** The member expressed dissatisfaction that their drug, **DRUG** changed tiers from one year to another.

**ACTION** A review of the current year formulary confirms that the drug is listed as a Tier **NUMBER** drug.

A review of the previous year formulary confirms that the drug was listed as a Tier **NUMBER** drug.

The Plan sent the member the plan materials, which provided important plan information. Members are provided with sufficient time to review any changes and decide whether the plan will continue to meet their needs in the next year. It is sometimes necessary to place a drug on a higher tier because lower cost generics or alternatives are available on a lower tier.

**RESULT** The Plan apologized for their drug changing to a higher tier. Plan advised the member to speak to their physician for a lower cost alternative if available.

The Plan provided Extra Help information and encouraged the member to contact the Social Security Administration at 1.800.772.1213. If they qualify, Medicare could help pay a portion of their drug costs including monthly prescription drug premiums, annual deductibles and copays. The member can also apply for Extra Help online at the Prescription Help section of www.socialsecurity.gov.

The Plan advised the member of the State Pharmacy Assistance Program available in their state if applicable.

**If applicable, include:**

**A TIER EXCEPTION REQUEST WAS SUBMITTED.**

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| **Cost of Medication Increased (BENEFITS)** |

 REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON**The member expressed dissatisfaction that the cost of **DRUG**increased.

**ACTION**The Plan provided the member with access to their Plan materials which included a Formulary list of covered drugs, Pharmacy Directory or Pharmacy and the Evidence of Coverage booklet. The formulary and EOC are also available on the Plans website.

With healthcare costs continuing to rise, the Plan remains committed to providing ways to reduce prescription drug costs for our members. The Plan carefully reviewed our copay or coinsurance amounts to provide the most cost-effective plan design.

**RESULT**The Plan apologized for any dissatisfaction this may have caused.The Plan advised the member to review, What you pay for your Part D Prescription drugs of their EOC.

Drug costs can vary depending on the quantity of medication dispensed, or if there is a price increase from the manufacturer. The plan may remove a drug from the formulary or change the tier based on price negotiations with the manufacturer for the new plan year.

The Plan provided Extra Help information and encouraged the member to contact the Social Security Administration at 1.800.772.1213. Medicare could help pay a portion of theirdrug costs including monthly prescription drug premiums, annual deductibles, and copays. The member can also apply for Extra Help online at the Prescription Help section of www.socialsecurity.gov.

**IF STATE PHARMACY ASSISTANCE PROGRAM INFORMATION WAS PROVIDED, INCLUDE:**

The Plan advised the member of the State Pharmacy Assistance Program available in their state.

**IF A CDA SUPPORT TASK WAS CREATED FOR A TIER EXCEPTION, INCLUDE:**

A CDA Support Task was created to submit a tier exception request.

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| **Unhappy with Transition Fill Process (BENEFITS)** |

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**REASON** The member expressed dissatisfaction with the transition fill process.

**ACTION** The Plan provided the member with access to the Formulary. The Formulary is a list of covered drugs selected by the Plan in consultation with a team of healthcare providers.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.A review of the formulary confirms a Coverage Determinationis required for coverage of **DRUG**. The Plan has confirmed a 30 day supply of the drug was filled under a transition fill. Further fills of the drug cannot be satisfied without an approved coverage determination.

The member was informed that a TF provides members with appropriate therapy and prevents gaps in drug coverage while educating members, prescribers, and pharmacy providers on formulary options. Transition fills are provided during the first 90 days from the members eligibility effective date or the first 90 days after the member experiences a plan change. Members and prescribers are then sent a written notice via U.S. Mail, within three business days of receiving a TF, to notify the member that a transition supply was provided and the member should work with the prescriber to discuss switching to a formulary drug or pursue an exception request with the Plan. The Plan has confirmed a TF notification for the drug was sent to the members address.

**If applicable, include:**

**MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| **Plan Not Paying towards Prescriptions (BENEFITS)** |

**REASON** The member expressed dissatisfaction regarding the Plan not paying towards the cost of their prescriptions.

**ACTION** The Plan provided the member with access to the Evidence of Coverage booklet.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan advised the member to review, What you pay for your Part D Prescription drugs, of their EOC. If the covered drug costs less than the copay coinsurance amount, the member will pay the lower price for the drug. The Plan will only pay on a drug when the allowed cost is over the members standard copay coinsurance.

Although it may seem as though the Plan is not assisting the member with their drug costs, the member is still receiving benefits and discounts as a member of the Plan. Plan educated member that without the benefit of their prescription drug plan, they would pay the cost submitted by the pharmacy. The Plan negotiates pricing with each pharmacy, therefore, they pay the allowed cost of the drug or the plan copay coinsurance, whichever is less.

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| **Dissatisfaction with Amount Plan Paid Towards Prescriptions (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**Note:** Refer to Financial Details, Total Client Cost in Compass or the EOB for Plan paid amount **(DO NOT INCLUDE THIS PART IN GRIEVANCE DESCRIPTION OF ISSUE).**

**REASON** The member expressed dissatisfaction regarding the amount the Plan paid towards the cost of their prescriptions. The Plan confirmed that the drug in question is **DRUG**.

**ACTION** The Plan provided the member with access to the Evidence of Coverage booklet.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan advised the member to review, What you pay for your Part D Prescription drugs, of their EOC. The Plan confirmed the Plan paid **AMOUNT** towards the claim. The Plan confirmed that the claim processed correctly. The Plan advised the member to review their Explanation of Benefits if they have questions regarding what the Plan pays towards their prescriptions.

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| **Recoupment Process Dissatisfaction (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction with the plans recoupment process for prior claims.

**ACTION** The Plan routinely audits prescription drug claims to verify if they were processed correctly. The amount the member pays for a drug depends on which coverage stage the member is in at the time a prescription is filled, the tier of the drug and the pharmacy used to fill the prescription.

The members prescription drug claims were reviewed for accuracy, and the Plan determined some of the members prescription claims required an adjustment. As a result, a recoupment invoice statement was mailed to the members address on file.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan advised that per Medicare guidelines, the Plan is required to make a reasonable effort to collect the balance due as a result of the claims being reprocessed. Therefore, this is a valid attempt to collect payment that was owed on the members account at the time of processing. If payment is not received, the Plan does not report any unpaid balances to an outside collection agency which may impact the members credit. This will not affect the members enrollment with the Plan.

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| **Dissatisfaction with Cost after Approved Formulary Exception (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction with the cost of their drug after receiving a formulary exception.

**ACTION** Plan confirms the member received an approved formulary exception for **DRUG**.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan advised the member to review: What is an Exception of their Evidence of Coverage.

This section informs the member that if the Plan agrees to make an exception and cover a drug that is not on the formulary, the member will need to pay the cost sharing amount that applies to drugs in the formulary exception Tier. The member cannot ask for an exception to the copayment or coinsurance amount the plan requires them to pay for the drug.

The Plan advised the member to speak to their prescriber regarding a lower cost alternative.

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| **Dissatisfaction with Cost Due to Deductible (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**Note** If the member is enrolled in an enhanced plan that provides continued coverage for lower tiers during the Deductible Stage, and the member is calling about the cost of a specific drug, a Tier Exception should be filed in lieu of a FCR Grievance unless the drug is a brand name in Tier 3.

**REASON** The member expressed dissatisfaction with the cost of their drug due to having to meet a deductible.

**ACTION** The Plan confirms the member has a **AMOUNT OF DEDUCTIBLE** for their current plan.

**RESULT** The member was advised to refer to, What You Will Pay for Your Part D Prescription Drugs, During the Deductible Stage, you pay the full cost of your drugs of their Evidence of Coverage.

The Deductible Stage is the first payment stage of drug coverage. This stage begins when the member fills their first prescription in the year. When in this payment stage, they must pay the full cost of their drugs until they reach the plans deductible amount.

Once the member has paid the deductible, they leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Phase.

The Plan apologized for any inconvenience or frustration this issued has caused.

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| **Dissatisfaction with Plan’s Override Policy (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction due to the Plans override policy regarding **INSERT TYPE OF OVERRIDE**.

**ACTION** The Plan conducts a Drug Utilization Review DUR of the members prescriptions to ensure that benefits are being administered according to the terms of coverage, as well as ensuring the members health safety.

**RESULT**

**Use one of the following:**

1. **PBO Allowed Verbiage**

Per the Plan design **TYPE OF PBO** is allowed **SPECIFY RESTRICTIONS**. There are certain circumstances where the member may receive a Plan Benefit Override PBO to obtain their drug if the refillable date has not been reached. A PBO is used to override a plans terms and conditions by applying a systemic override code. The Plan confirmed a PBO was allowed for **DRUG**.

1. **PBO Not Allowed Verbiage**

A Plan Benefit Override PBO is used to override a plans terms and conditions by applying a systemic override code. Regrettably, per the Plan design a **TYPE OF PBO** is not allowed. If the member is in dire need of the drug, they may pay out of pocket or request samples if available from their prescriber.

The Plan apologized for any inconvenience or frustration this issued has caused.

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| **Dissatisfaction with Utilization Rate (BENEFITS)** |

REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

***Note Check CIF for DUR information.***

**REASON** Member expressed dissatisfaction with only being able to refill prescriptions at specific times.

**ACTION** The members prescription benefit determines how many days must pass before allowing them to obtain their next refill. This is known as the Drug Utilization Rate. The members plan benefits allow a drug to be refilled per the following DUR

* Mail Service Pharmacy When **PERCENTAGE** percent of the day supply has been utilized. This provides the member enough time to order a refill, for the mail service pharmacy to process it, to reach out to the prescriber if necessary, and allows sufficient time for delivery to the members door.
* Retail Pharmacy When **PERCENTAGE** percentof a 30 day supply has been utilized or **PERCENTAGE** for a 90 day supply.

The utilization rate is not meant to be an inconvenience but to ensure drugs are filled only when necessary.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The Plan advised the member of our commitment to help members get the most benefit from their prescriptions and to understand how their coverage works. If the member is out of medication due to a specific circumstance, an override may allow them to receive the medication sooner than the refill date.

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| **Drug Not Eligible for Tier Exception (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction because **DRUG** is not eligible for a Tier Exception.

**ACTION** The Plan provided the member with access to the Formulary, Pharmacy Directory and the Evidence of Coverage booklet. The Formulary informs the member of which drugs are covered and their tier levels.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.A review of the formulary shows the drugis listed as a covered Tier **NUMBER** drug. The drug is listed at the lowest cost share tier allowed by the Plan and therefore, is not eligible for a Tier Exception. The Plan advised the member to speak to their prescriber regarding a lower cost alternative.

**For a Tier 5 specialty drug:**

A review of the formulary shows the drugis listed as a covered Tier 5 specialty drug. Unfortunately, Tier 5 drugs are ineligible for a Tier Exception. The Plan advised the member to speak to their prescriber regarding a lower cost alternative.

The Plan provided Extra Help information and encouraged the member to contact the Social Security Administration at 1.800.772.1213. If they qualify, Medicare could help pay a portion of theirdrug costs including monthly prescription drug premiums, annual deductibles and copays. The member can also apply for Extra Help online at the Prescription Help section of www.socialsecurity.gov. The Plan advised the member of the State Pharmacy Assistance Program SPAP available in their state, if applicable.

**Note:** For approved non formulary drugs that are ineligible for a tier exception, refer to [Dissatisfaction with Cost after Approved Formulary Exception](#CostAfterApprovedFormExecpt).

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| **Received Transition Fill and Not the Full Day Supply (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that **DRUG** was not filled for the full prescribed day supply.

**ACTION** The Plan confirms the drug was filled as a transition fill.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.A review of the formulary confirms a Coverage Determinationis required for coverage of the drug.

Although the prescription was written for a higher day supply, the written day supply exceeded the TF plan limitations. Therefore, the prescription could not be filled for the full day supply without an approved coverage determination.

The member was informed that a TF provides members with appropriate therapy and prevents gaps in drug coverage while educating members, prescribers, and pharmacy providers on formulary options. Transition fills are provided during the first 90 days from the members eligibility effective date or the first 90 days after the member experiences a plan change. The Plan allows multiple fills up to a 30 day supply. Members and prescribers are then sent a written notice via U.S. Mail, within three business days of receiving a TF, to notify the member that a transition supply was provided and the member should work with the prescriber to discuss switching to a formulary medication or pursue an exception request with the Plan. The Plan has confirmed a TF notification for the drug was sent to the members address.

**If applicable, include:MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| **EOB Shows Inappropriate Billing by Pharmacy (Claim Already Reversed) (BENEFITS)** |

**** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their Explanation of Benefits reports indicates they were billed for **DRUG** which they do not take.

**ACTION** A review of the members prescription claim history shows a claim for the drug was processed and reversed at **PHARMACY NAME**. The member was informed that this claim will be shown as reversed in their next EOB cycle.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.

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| **EOB Shows Inappropriate Billing by Pharmacy (Pharmacy Needs to Reverse Claim) (BENEFITS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their Explanation of Benefits reports indicates they were billed for **DRUG** which they do not take.

**ACTION** A review of the members prescription claim history shows a paid claim for the drug at the **PHARMACY NAME**.

The Plan contacted the pharmacy in regards to the members concerns, and the pharmacy representative successfully reversed the claim. The member was informed that this claim will be shown as reversed in their next EOB cycle.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.

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| **Dissatisfied with Drug Not Covered under the Inflation Reduction Act (BENEFITS)** |

REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction with **DRUG** not being covered under the Inflation Reduction Act.

**ACTION** The Plan provided the member with access to their Plan materials which included a Formulary list of covered drugs, Pharmacy Directory or Pharmacy and the Evidence of Coverage booklet. The Formulary informs the member of which drugs are covered and their tier levels. The plan has different copays and coinsurances based on the tier level of each medication and stage of coverage that the member is in; the Plan informed the member this information was included in their EOC, What you pay for your Part D prescription drugs. The formulary and EOC are also available on the Plans website.

The Plan confirmed the drug in not listed as an approved drug under the Inflation Reduction Act, and will therefore, be subject to the Plans copay/coinsurance.

The Plan advised that the Inflation Reduction Act only covers those adult Part D vaccines recommended by the Centers for Disease Control and Preventions Advisory Committee on Immunization Practices at 0.00 for individuals 19 years of age and older and covers a one month supply of each covered Part D insulin product with a copay of no more than 35.00, no matter what cost-sharing tier it is on, and will not charge a deductible. The 35.00 insulin copay cap only applies to products that contain a form of insulin.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan encouraged the member to utilize a preferred pharmacy or the mail service pharmacy to lower the costs of their medications. The Plan also advised the member to discuss lower cost alternatives with their prescriber.

The Plan provided Extra Help information and encouraged the member to contact the Social Security Administration at 1.800.772.1213. Medicare could help pay a portion of their drug costs including monthly prescription drug premiums, annual deductibles, and copays. The member can also apply for Extra Help online at the Prescription Help section of www.socialsecurity.gov.

**IF STATE PHARMACY ASSISTANCE PROGRAM INFORMATION WAS PROVIDED, INCLUDE:**

The Plan advised the member of the State Pharmacy Assistance Program available in their state.

**If applicable, include:**

**MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| **Higher Copay at Retail than Mail Order (BENEFITS)** |

****REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that they have a higher copay for **DRUG** when using a retail pharmacy than when using a mail service pharmacy.

**ACTION** A review of the current year formulary confirms that the drug is listed as a Tier **NUMBER** drug. The Plan confirmed that the member is responsible for a cost share amount of **AMOUNT** for a **NUMBEROFDAYSUPPLY** at a retail pharmacy rather than a cost share amount of **AMOUNT** for a **NUMBEROFDAYSUPPLY** at a mail service pharmacy.

The Plan provided the member with access to their Plan materials which included a Formulary list of covered drugs, Pharmacy Directory or Pharmacy and the Evidence of Coverage booklet. The Formulary informs the member of which drugs are covered and their tier levels. The plan has different copays and coinsurances based on the tier level of each medication and stage of coverage that the member is in. The Plan informed the member this information was included in their EOC, What you pay for your Part D prescription drugs. The formulary and EOC are also available on the Plans website.

With healthcare costs continuing to rise, the Plan remains committed to providing ways to reduce prescription drug costs for our members. The Plan carefully reviewed our copay or coinsurance amounts to provide the most cost effective plan design. The Plan may provide a lower cost at a mail service pharmacy to encourage members to utilize this service for their maintenance drugs however, not all drugs are available at a mail service pharmacy.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan encouraged the member to utilize a preferred pharmacy to lower the costs of their medications. The Plan also advised the member to discuss lower cost alternatives with their prescriber.

The Plan provided Extra Help information and encouraged the member to contact the Social Security Administration at 1.800.772.1213. Medicare could help pay a portion of their drug costs including monthly prescription drug premiums, annual deductibles, and copays. The member can also apply for Extra Help online at the Prescription Help section of www.socialsecurity.gov.

**IF STATE PHARMACY ASSISTANCE PROGRAM INFORMATION WAS PROVIDED, INCLUDE THE FOLLOWING**

The Plan advised the member of the State Pharmacy Assistance Program available in their state.

**If applicable, include:**

**MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| Medicare Prescription Payment Plan First Invoice Higher than Expected (BENEFITS) |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their first Medicare Prescription Payment Plan invoice or balance is higher than expected.

**ACTION** Plan records show the member has a balance due in the amount of **AMOUNT** for **MONTH**.

The Plan advised that the first months bill for the Medicare Prescription Payment Plan is calculated differently than the bill for the remaining months of the year.

The Plan determines the members maximum possible payment for the first month. This would be **166.67 OR AMOUNT** as the members annual out of pocket cost for 2025 is 2,000.00, which is split over the remaining months in the year. This amount is mandated by the Centers for Medicare and Medicaid. The Plan then compares that to their total out of pocket expense, which was **166.67 OR AMOUNT**. The Plan will bill the member the lesser of the two amounts which was **166.67 OR AMOUNT**. That leaves the member with a remaining balance of **166.67 OR AMOUNT**. The remaining balance will be spread over the remaining months left in the year.

**RESULT** The Plan apologized for any inconvenience this may have caused. The Plan advised that payments might change every month, so beneficiaries might not know what their exact bill will be ahead of time. Future payments might increase when they fill a new prescription or refill an existing prescription because as new out of pocket drug costs get added into their monthly payment, there are fewer months left in the year to spread out remaining payments.

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| Dissatisfaction With not Receiving a Medicare Prescription Payment Plan Invoice (BENEFITS) |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they did not receive a Medicare Prescription Payment Plan payment invoice.

**ACTION** Plan records show a Medicare Prescription Payment Plan Monthly Billing Statement was mailed to the members address on file on **DATE** reflecting a total cost share due of **AMOUNT**, which was due on **DATE**.

**RESULT** The Plan apologized for any inconvenience this may have caused. The Plan advised that invoices are generated on the third of the month with a due date of the 25th of the month. The Plan advised the member to make payments timely to ensure they are received prior to the due date.

**If applicable, include:**

**The Plan processed a payment on the members behalf.**

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| Medicare Prescription Payment Plan Invoice Received After Payment Made (BENEFITS) |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they received a Medicare Prescription Payment Plan invoice after having made a payment.

**ACTION** Plan records show a Medicare Prescription Payment Plan Monthly Billing Statement was mailed to the members address on file on **DATE** reflecting a total cost share due of **AMOUNT**, which was due on **DATE**.

The members last payment was received on **DATE** via **METHOD** in the amount of **AMOUNT**. As this payment was posted to their account after the due date, the invoice mailed to the member did not reflect this payment.

**RESULT** The Plan apologized for any inconvenience this may have caused. The Plan advised that payments made after the due date may not be reflected until the next billing statement is generated. The Plan advised the member to make payments timely to ensure they are received prior to the due date. The Plan provided the member with alternate payment methods.

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| Dissatisfaction With the Medicare Prescription Payment Plan Due Date (BENEFITS) |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied with the Medicare Prescription Payment Plan payment due date.

**ACTION** Plan records show a Medicare Prescription Payment Plan Monthly Billing Statement was mailed to the members address on file on **DATE** reflecting a total cost share due of **AMOUNT**, which was due on **DATE**.

**RESULT** The Plan apologized for any inconvenience this may have caused. The Plan advised that invoices are generated on the third of the month with a due date of the 25th of the month. The Plan advised the member to make payments timely to ensure they are received prior to the due date.

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| Medicare Prescription Payment Plan Invoice Amounts Differ Monthly (BENEFITS) |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their Medicare Prescription Payment Plan monthly balance differs from month to month.

**ACTION** Plan records show the member has a balance due in the amount of **AMOUNT** for **MONTH**.

The Plan advised that their total out of pocket expense is split over the remaining months left in the year until the annual out of pocket cost of 2,000.00 in 2025 is reached. This amount is mandated by the Centers for Medicare and Medicaid.

**RESULT** The Plan apologized for any inconvenience this may have caused. The Plan advised that payments might change every month, so beneficiaries might not know what their exact bill will be ahead of time. Future payments might increase when they fill a new prescription or refill an existing prescription because as new out of pocket drug costs get added into their monthly payment, there are fewer months left in the year to spread out remaining payments.

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| **CMS ISSUES** |

Refer to [Compass MED D - How to File a Grievance in Compass for Health Plans, JE](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) for further information.

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| **Unable to Use Coupon with Plan Benefits (CMS ISSUES)** |

**REASON** The member is dissatisfied that they are unable to utilize coupons in addition to the Plans coverage benefits.

**ACTION** Medicare regulations state that members are not able to use any coupons, pharmacy discount cards or private drug discount cards in conjunction with their Medicare Part D benefits. Coupons or discount cards provide a discount on the retail price of the drug not otherwise covered by insurance. Since people with Medicare prescription drug coverage have insurance, further discounts do not apply. However, the member may use a coupon or discount card for a prescription drug if they do not use their insurance and pay out of pocket. The member was advised that if they can use the coupon and pay out of pocket, their cost will not be added to their total drug cost or true out of pocket accumulation.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. As an alternative to a discount program, the member is encouraged to use a preferred pharmacy to lower their cost or speak to their provider about a lower cost alternative.

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| **Low Income Subsidy (LIS) Copay Dissatisfaction (CMS ISSUES)** |

**REASON** The member expressed dissatisfaction because their Low Income Subsidy copays are too high.

**ACTION** The Plan informed the member that an LIS Rider was provided informing the member that they will pay the LIS copays instead of the plan copays.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The Plan educated the member that the LIS copays are established by the Centers for Medicare and Medicaid Services and not the Plan. The LIS copays change annually. The member may appeal the level of subsidy with CMS.

The Plan also educated the member that if the Plans copays are less than the LIS copays, the member will pay the lesser amount.

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| **Medication Not Covered Under Med D Law (CMS ISSUES)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction with their drug **DRUG** not being covered under Medicare Part D law.

**ACTION** There are some drugs that are excluded from Medicare coverage by law. These include drugs for

* Anorexia, weight loss or weight gain, except to treat physical wasting caused by AIDS, cancer or other diseases
* Fertility
* Cosmetic purposes or hair growth
* Relief of the symptoms of colds, like a cough and stuffy nose
* Erectile dysfunction
* Prescription vitamins and minerals, except prenatal vitamins and fluoride preparations
* Non prescription drugs over the counter drugs

**RESULT** The Plan apologized for any dissatisfaction this may have caused.Prescription drugs used for the above conditions will not be covered by Medicare Part D. However, they may be covered if they are being prescribed to treat other conditions. For example, prescription drugs for the relief of cold symptoms may be covered by Part D if prescribed to treat something other than a cold such as shortness of breath from severe asthma if they are approved by the United States Food and Drug Administration for such treatment. In these circumstances the member can request a formulary exception for coverage of the drug.

**If call is transferred to Clinical Team to discuss alternatives include:**

The member was transferred to the Clinical Team to discuss alternatives that are covered under Medicare Part D law.

**If member does not want to be transferred to Clinical Team:**

The member was advised to speak to their prescriber regarding an alternative drug that is covered under Medicare Part D law.

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| **Dissatisfaction with 7 Day Supply Opioid Limit (CMS ISSUES)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that they were only able to receive a seven day supply of **DRUG** although the prescription was written for a greater day supply due to being a CMS requirement.

**ACTION** The Plan advised that only members who have not filled an opioid prescription recently past 108 days or who are newly starting opioids may be limited to a seven day supply. After this initial fill of up to seven days, future opioid prescriptions will pay through their plan as long as the amount is within Quantity/Plan Limits.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. If the member does not want to proceed with the initial seven day fill, and would like the full prescription amount, they will need to file a Coverage Determination CD for a quantity limit exception.

**If applicable, include:MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| **CUSTOMER SERVICE** |

Refer to [Compass MED D - How to File a Grievance in Compass for Health Plans, JE (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) for further information.

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| **Plan Unable to Fax or Email Information (CUSTOMER SERVICE)** |

**REASON** The member is dissatisfied that the Plan is unable to fax or email certain information.

**ACTION** The member was informed that the Centers for Medicare and Medicaid Services requires certain plan materials to be sent via postal mail.

Documents containing Protected Health Information must be sent via postal mail or through a secured website account.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.

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| **Charged Different Price than Quoted by Care (CUSTOMER SERVICE)** |

**REASON** The member is dissatisfied that they were charged a different price than what was quoted by Customer Care.

**ACTION** The member was educated that their out of pocket cost is subject to change after placing the initial order. Drug costs can vary depending on the strength and quantity of the drug dispensed or if there is a price increase from the manufacturer. Furthermore, the price estimate tool or test claim provides estimates, and the actual cost may vary based on the order in which the member purchases the prescriptions plan benefit stage.

**RESULT** The Customer Care Representative read the following disclaimer at the time of placing the order, Please note the prices quoted are estimates and may not reflect your actual out of pocket costs. The Plan apologized for any dissatisfaction this may have caused.

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| **Upset with Being Contacted by the ADT Program (CUSTOMER SERVICE)** |

**REASON** The member is dissatisfied that they were contacted by the Adherence to Drug Therapy program.

**ACTION** The member was educated that the Plans Adherence to Drug Therapy program is a disease management program designed to improve members adherence with their drug therapy. CVS Caremark offers the ADT program at no cost to the member. The program is voluntary, and members or prescribers can request to be excluded at any time. They were additionally advised that if they or their doctor changes their mind, they could be reinstated in the program.

**RESULT**

* **If the member wishes to opt out:**

The members request to opt out of the ADT program was submitted on their behalf. The Plan apologized for any dissatisfaction this may have caused.

* **If the member does not request to opt out:**

After educating the member about the ADT program, they wished to remain in the program.

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| **Long Hold Time (to Reach a CCR) (CUSTOMER SERVICE)** |

**REASON** The member expressed dissatisfaction with the long hold time when attempting to reach a live representative.

**ACTION** The Plan informed the member that hold times can be longer than usual during specific times of the plan year.

**RESULT** The member was advised that to avoid long wait times, it is recommended to call during non peak hours such as early in the morning, in the evenings or during weekend hours.

The Plan apologized for any inconvenience or frustration this issue has caused.

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| **Long Hold Time (Placed on Hold by CCR) (CUSTOMER SERVICE)** |

**REASON** The member expressed dissatisfaction with the long hold time.

**ACTION** The Plan advised that to resolve theirissue it was necessary for the Customer Care Representative to place them on hold to conduct additional research.

**RESULT** The member was advised that although the Plan strives to keep hold times to a minimum, the complexity of an issue may increase the amount of time a member may have to spend on the phone. CCRs are instructed to check back with the member every two minutes to inform them their issue is still being researched.

The Plan apologized for any inconvenience or frustration this issued has caused.

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| **Call Disconnected (CUSTOMER SERVICE)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that their call was disconnected.

**ACTION** A review of the members call log indicates a disconnected call on **DATE**. The Plan confirmed the disconnection was not intentional by the Customer Care Representative CCR.

**RESULT** The Plan apologized for any inconvenience or frustration this issued has caused and assisted the member with their inquiry.

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| **Multiple Transfers During Call (CUSTOMER SERVICE)** |

**REASON** The member expressed dissatisfaction that they were transferred multiple times.

**ACTION** The Plan advised that to resolve their issue it was necessary to transfer the member to the appropriate department for further assistance.

**RESULT** It is the Plans goal to provide members with the necessary information and services to manage their prescription drug benefits.

The member was advised that although the Plan strives to keep call transfers to a minimum, the complexity of an issue and issue type may require to be transferred to the correct department.

The Plan apologized for any inconvenience or frustration this issued has caused.

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| **Authentication Process (CUSTOMER SERVICE)** |

**REASON** The member expressed dissatisfaction with having to authenticate themselves.

**ACTION** The Plan is required by the Health Insurance Portability and Accountability Act of 1996, to protect the members Personal Health Information. The Plan is required to comply with policies and procedures to protect the confidentiality of health information and will be subject to a disciplinary process if they violate these policies and procedures.

**RESULT** The Plan advised that to protect their privacy, the Plan must authenticate a call by obtaining at least one of the primary authentication elements the Member Identification Number, Medicare Member Identifier or prescription number and name. The brand or generic prescription name is an acceptable authenticator. If the Plan is unable to obtain at least one of the above primary authenticators, the caller can call again once they can provide the required information.

Secondary authenticators may be the members first and last name. First and last name can be used as an identifier for inbound calls only. Members date of birth, full street address, employer or plan sponsor, zip code.

**If transferred to Customer Care by IVR:**

The member may enter information into the IVR that was not translated in the main system. For their protection, the Customer Care Representative may have to ask the member to repeat their information to ensure they are speaking to the correct member.

Although it may seem inconvenient, the intent is to make sure the member is who they say they are and to ensure no PHI is released.

The Plan apologized for any dissatisfaction this may have caused.

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| **Offshore Customer Care Sites (CUSTOMER SERVICE)** |

**REASON** The member expressed dissatisfaction that they reached a Customer Care Representative outside of the United States.

**ACTION** The Plan advised that the CVS Caremark Customer Care call center dedicated to answering calls for the Plan does not have offshore CCRs, however, the member may have reached a different department that does not handle calls for the Plan.

**RESULT** The Plan educated the member that they can reach the call center dedicated to handling calls for the Plan by calling the phone number on the back of their membership identification card. The Plan apologized for any dissatisfaction this may have caused.

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| **ENROLL/DISENROLL** |

Refer to [Compass MED D - How to File a Grievance in Compass for Health Plans, JE (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) for further information.

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| **CMS Facilitated Their Enrollment into Part D Plan Against Their Wishes (ENROLL/DISENROLL)** |

**REASON** The member is dissatisfied that they were facilitated into the Plan without their consent.

**ACTION** The Plan educated the member that the Centers for Medicare and Medicaid Services will initiate a facilitated enrollment into a Prescription Drug Plan for Medicare members who are eligible for Low Income Subsidy also known as Extra Help but not eligible for full Medicaid benefits. If the member has yet to elect a PDP, after two months of being eligible for LIS, CMS will facilitate an enrollment into a PDP to ensure the member has prescription drug coverage.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The Plan educated the member that CMS allows them to enroll, switch, or disenroll from a PDP within three months of the start of coverage in their assigned plan or notification of enrollment, whichever is later. LIS eligible members can also make plan changes once per calendar quarter during the first nine months of the year, this SEP cannot be used during October to December.

The member was provided with ways to voluntarily disenroll from a PDP, such as submitting a valid written disenrollment request that includes their disenrollment reason and signature, calling 1.800.MEDICARE, 1.800.633.4227, or enrolling into another Medicare PDP.

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| **CMS Auto-Enrolled Into Part D Plan Against Their Wishes ENROLL/DISENROLL** |

**REASON** The member is dissatisfied that they were auto enrolled into the Plan without their consent.

**ACTION** The Plan educated the member that the Centers for Medicare and Medicaid Services will initiate an enrollment into a Prescription Drug Plan for Medicare members who are eligible for Low Income Subsidy also known as Extra Help and also eligible for full Medicaid benefits. If the member has yet to elect a PDP, CMS will auto enroll them into a PDP to ensure the member has prescription drug coverage.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan educated the member that CMS allows them to enroll, switch, or disenroll from a PDP within three months of the start of coverage in their assigned plan or notification of enrollment, whichever is later. LIS eligible members can also make plan changes once per calendar quarter during the first nine months of the year, this SEP cannot be used during October to December.

The member was provided with ways to voluntarily disenroll from a PDP, such as submitting a valid written disenrollment request that includes their disenrollment reason and signature, calling 1.800.MEDICARE 1.800.633.4227, or enrolling into another Medicare PDP.

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| **Dissatisfied with Disenrollment Process (ENROLL/DISENROLL)** |

**REASON** The member is dissatisfied with the disenrollment process.

**ACTION** The Plan educated the member that CMS allows them to enroll, switch, or disenroll from a PDP during the Annual Election Period of October 15 through December 7 each year. Changes during other times of the year are not allowed unless they qualify for a Special Election Period SEP.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The member was provided with ways to voluntarily disenroll from a PDP, such as submitting a valid written disenrollment request including disenrollment reason and signature, calling 1.800.MEDICARE, 1.800.633.4227, or enrolling into another Medicare PDP.

Upon receipt of the disenrollment request, the Plan will assess for a valid disenrollment period. If valid, the Plan will send the disenrollment request to CMS for approval. The Plan will then disenroll the member for the first of the following month and send them a confirmation of disenrollment letter or inform them their disenrollment request was denied.

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| **Received Multiple** **Residence Verification Forms (RVF) (ENROLL/DISENROLL)** |

**REASON** The member is dissatisfied that they continue to receive Residence Verification Forms RVF.

**ACTION** The Plan advised that an individual must reside within the Plans service area to be eligible for a Medicare Part D Prescription Drug Plan. Drug plans are notified of a possible address change that is outside the PDP service area from either the Centers for Medicare and Medicaid Services or from the United States Postal Service via undeliverable mail. Once the Plan is notified, the Plan is required to make an attempt to contact the member to determine a correct permanent address. The Plan fulfills this requirement by sending the member an Out of Area letter that has an RVF enclosed to complete and return to the Plan.

The member was advised that the Plan received notification from CMS or USPS that their address had changed and they were now OOA.

The Plan mailed RVFs to the address on file requesting that the member contact us to verify the address to prevent them from being disenrolled due to being OOA.

The member was advised that the Plan received notice of the members new address, after the RVFs were mailed. The Plan apologized for any dissatisfaction this may have caused.

**RESULT**

* **If removed from OOA process:**

The members address was updated as requested and they were removed from the OOA process.

* **If address has to be updated still in service area:**

A request was submitted to update the members address as requested. A new enrollment was not required as they remain in the same region.

* **If address has to be updated NOT in service area:**

A request was submitted to update the members address as requested and they were transferred to the enrollment team to submit a new enrollment.

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| **Received Residence Verification Form (RVF) but Did Not Move (ENROLL/DISENROLL)** |

**REASON** The member is dissatisfied that they received a Residence Verification Form although they have not moved.

**ACTION** The member was informed that an individual must reside within the Plans service area to be eligible for coverage. The Plan is notified of a possible address change that is outside the PDP service area from either the Centers for Medicare and Medicaid Services via Transaction Response Code or from the United States Postal Service USPS via undeliverable mail. Once the Plan is notified, the Plan is required to make an attempt to contact the memberto determine their correct permanent address. The Plan fulfills this requirement by sending the member an Out of Area letter that has a Residence Verification Form RVF.

Records indicate that the Plan received notification indicating the members address had changed and they were now OOA.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The member confirmed that they had not moved and their address remains the same. A request was submitted confirming the members address to remove them from the OOA process.

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| **Multiple Attempts to Disenroll (ENROLL/DISENROLL)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they remain enrolled in the Plan after multiple disenrollment requests.

**ACTION** The Plan educated the member that CMS allows them to enroll, switch, or disenroll from a PDP during the Annual Election Period of October 15 through December 7 each year. Changes during other times of the year are not allowed unless they qualify for a Special Election Period.

Upon receipt of the disenrollment request, the Plan will assess for the AEP, or if applicable, SEP. If valid, the Plan will send the disenrollment request to CMS for approval. The Plan will then disenroll the member for the first of the following month and send them a confirmation of disenrollment letter or inform them their disenrollment request was denied.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan has confirmed that this is not the members initial request to disenroll. However, the members previous disenrollment request was denied due to the request not being completed due to not having a valid SEP out of the AEP. The member was informed that they can disenroll during the AEP or submit a valid completed disenrollment request with a SEP.

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| **Initial Enrollment Period (IEP) Effective Date (ENROLL/DISENROLL)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied with their effective enrollment date and indicated their coverage should start **DATE**.

**ACTION** The Initial Enrollment Period for Part D is the period during which an individual is first eligible to enroll in a Part D plan, this is a seven month period surrounding Medicare eligibility. The Plan has confirmed the members enrollment was during the members IEP.

**RESULT** CMS provides specific enrollment effective dates for when a member enrolls during their seven month IEP and cannot be modified. Plan apologized and confirmed the effective date is valid.

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| **Incorrect Address on File (ENROLL/DISENROLL)** |

**REASON** The member is dissatisfied that the incorrect address is on file.

**ACTION** The Plan has confirmed that this is the members initial request to update their address. The members address was updated as requested.

**RESULT** The Plan apologized to the member for any dissatisfaction this may have caused.

* **Updated address still in service area**

A new enrollment was not required for the member as they remain in the same region.

* **Updated address NOT in service area**

The member was transferred to the enrollment team to submit a new enrollment as their new address is no longer in the same service area.

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| **Too Much Mail (ENROLL/DISENROLL)** |

**REASON** The member is dissatisfied that they are receiving too much mail.

**ACTION** The Plan informed the member that Medicare requires the plan to send certain documents such as an Annual Notice of Change, Welcome Kit, and other letters with important plan information.

The Plan must also provide written correspondence whenever an attempt to contact the member via phone, such as an issue pertaining to a prescription order, is not successful.

* **If Plan allows for electronic EOBs:**

The member can opt in receiving electronic EOBs and they will no longer receive EOBs via mail, this can be changed at any time.

**RESULT** The Plan apologized for any dissatisfaction this has caused the member. The Plan advised that regrettably, the Centers for Medicare and Medicaid Services mandate that all Medicare Part D PDPs send these types of documents to all enrolled members.

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| **Explanation of Benefits - Does Not Want to Receive (ENROLL/DISENROLL)** |

**REASON** The member expressed dissatisfaction that Explanation of Benefit reports are being mailed.

**ACTION** All Medicare Part D Prescription Drug Plans are required by the Centers for Medicare and Medicaid Services to mail their members a monthly report, known as an EOB, if they have purchased any covered drugs within the prior month or if there are changes to their plan coverage. The EOB report contains comprehensive information on the cost sharing of drug purchases or drug claims, the members current prescription drug plan coverage stage, their progression towards the next coverage stage, and any important formulary changes to drugs covered by the Plan.

**RESULT** The Plan recommended that the member sign up for electronic EOBs. With electronic EOBs, a paper document is not mailed. Member has the option to print the EOB as needed. The Plan apologized for the members dissatisfaction.

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| **Unable to Enroll Due to No Special Enrollment Period (ENROLL/DISENROLL)** |

**REASON** The member expressed dissatisfaction with not being able to enroll at this time.

**ACTION** The Plan confirmed the member is not in their Initial Enrollment Period due to age or disability.

The Plan educated the member that the Centers for Medicare & Medicaid Services allows enrollment into a plan during specific time periods. The IEP lasts for seven months, three months prior to and three months after the month of eligibility either due to age or receiving a disability benefit. The Annual Election Period AEP is from October 15 through December 7 each year. CMS also provides Special Election Periods SEP for particular circumstances such as relocation to a different service region, loss of creditable coverage, or loss of Extra Help. Disenrollment due to nonpayment of plan premiums or needing drugs are not qualifying SEPs.

**RESULT** The Plan apologized for not being to enroll the member. Information regarding the members State Health Insurance and Assistance Program was provided to assist the member in finding other resources to obtain their prescriptions.

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| **Did Not Receive ID Card (ENROLL/DISENROLL)** |

**REASON** The member is dissatisfied that they did not receive their ID card.

**ACTION** The member was mailed Plan materials including a membership Identification card to the address on file.

**Include if address was incorrect** The member indicated their address was changed, therefore, the Plan updated their address per the members request.

**Include if pharmacy was contacted** As a courtesy, the Plan contacted their pharmacy and provided them with the processing information needed to process prescription claims through their plan benefits. The Plan additionally provided the member with the pharmacy processing information until they receive their new ID card.

The Plan informed the member that if they have paid out of pocket for any prescriptions, they may request reimbursement via the paper claims process. Paper claim forms can be mailed by the Plan or the member can obtain the forms online at their plans website.

**RESULT** The Plan submitted a request for a duplicate membership ID card to be mailed to the member and educated the member that they may also log on to their Caremark.com account to print a temporary membership ID card. The Plan apologized for the dissatisfaction this may have caused.

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| **EXCEPTIONS COVERAGE DECISIONS** |

Refer to [Compass MED D - How to File a Grievance in Compass for Health Plans, JE (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) for further information.

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| **Not Notified of Expiring Coverage Determination (EXCEPTIONS COVERAGE DECISIONS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that they were not notified that the coverage determination for **DRUG** was expiring.

**ACTION** A review of the formulary confirms a CD is required for coverage of the drug.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. ThePlan records show a CD for the drug was approved through **DATE**. The Plan advised that a letter of approval, which included the expiration date of the CD, was mailed to the address on file on the same day the CD was approved. Unfortunately, the Plan does not send expiration notices. The member was advised to make note of the expiration date listed on the CD approval letter in order to be aware of when it expires. The member was advised that a CD renewal can be submitted 90 days prior to the expiration of the CD.

**If applicable, include:**

**MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| **Physician Wrote Prescription So Additional Approval Should Not Be Necessary (EXCEPTIONS COVERAGE DECISIONS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that although prescribed by the physician, a coverage determination CD is required for coverage of **DRUG**.

**ACTION** The Plan materials were sent to the member**,** which provided important plan information.The Formulary informs the member of which drugs are covered and their tier levels. The Formulary is also available on the Plans website.

The Formulary is a list of covered drugs selected by the Plan in consultation with a team of healthcare providers. The Formulary represents the prescription therapies believed to be a necessary part of a quality treatment program. The Plan offers a broad selection of drugs while keeping plan costs controlled for members. All considerations were made based on the Food and Drug Administration approved recommendations, clinical studies and manufacturer guidelines.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The member was advised that although prescribed by the physician, certain prescription drugs require additional authorization or limit requirements may be in place. The member is required to obtain a CD before certain drugs will be covered. This process is not intended to cause an inconvenience, but rather to ensure drugs receive the highest in safety and quality monitoring.

In general, the Plan rules encourage members to get a drug that works for their medical condition and is safe and effective. Whenever a safe, lower cost drug will work just as well medically as a higher cost drug, the rules are designed to encourage the member and their provider to use that lower cost option. The Plan must also comply with Medicare rules and regulations for drug coverage and cost sharing.

A review of the formulary confirms a CDis required for coverage of the drug.

The Plan advised of the following options

Possibly get a temporary supply of the drug although only members in certain situations can get a temporary supply. This will give the member and their provider time to change to another drug or to file a request to have the drug covered.

Ask the physician to prescribe an alternative drug.

Request an exception and ask that a drug be covered or remove restrictions from the drug.

**If applicable, include:**

**MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| **Having to File Coverage Determination Annually (EXCEPTIONS COVERAGE DECISIONS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that a coverage determination must be filed annually.

**ACTION** The Plan provided the member access to the Formulary. The Formulary informs the member of which drugs are covered and their tier levels.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.Records show a CDfor **DRUG** was approved through **DATE**.

The formulary is updated at least once yearly. Therefore, a CD may need to be filed annually as the Plan must validate and collect current clinical information on file from the members physician for the drug. Other times, the drug may no longer require a coverage determination for that year and the member will continue to receive the drug with no further action necessary.

This process is not intended to cause an inconvenience, but rather to ensure drugs receive the highest in safety and quality monitoring.

**If CD is still required include:**

The drug requires a CD for the current plan year. The Plan advised of the following options:

Possibly get a temporary supply of the drug although only members in certain situations can get a temporary supply. This will give the member and their provider time to change to another drug or to file a request to have the drug covered.

Ask the physician to prescribe an alternative drug.

Request an exception and ask that a drug be covered or remove restrictions from the drug.

**If applicable, include:**

**MEMBER WAS PROVIDED FORMULARY ALTERNATIVES OR AN EXCEPTION WAS SUBMITTED**.

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| **Dissatisfaction with Turnaround Time of a Coverage Determination (EXCEPTIONS COVERAGE DECISIONS)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction with the turnaround time of a coverage determination.

**ACTION** Plan records show a coverage determination for **DRUG** was submitted on **DATE**.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The member was advised that a standard coverage determination decision is made within 72 hours from the date and time of receipt, but exception requests may be up to 408 hours or 17 days if a statement of medical necessity is needed from the prescriber. A decision for an expedited CD request is made within 24 hours from the date and time of receipt, but exception requests may be up to 360 hours or 15 days if a statement of medical necessity is needed from the prescriber.

For standard redetermination requests, a decision is made within seven calendar days from the date and time of receipt. For an expedited RD, a decision is made within 72 hours from the date and time of receipt.

The aforementioned turnaround times include nights, weekends, and holidays. The Plan advised that these timeframes are established and required of the Plan by Medicare.

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| **OTHER** |

Refer to [Compass MED D - How to File a Grievance in Compass for Health Plans, JE (066742)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) for further information.

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| **Dissatisfied with Functionality or Content on caremark.com (OTHER)** |

**REASON** The member expressed dissatisfaction specifically with the functionality or content of caremark.com.

**ACTION** The Plan apologized for any dissatisfaction this may have caused. The Plan assisted with their website concerns or questions.

**RESULT** The Plan confirmed that there are no issues with the website and it is functioning properly. The member was encouraged to contact Customer Care for any future inquiries they may have.

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| **Concerned that Information is being Shared Without Consent (OTHER)** |

**REASON** The member is dissatisfied that their information is being shared for marketing purposes.

**ACTION** The Plan informed the member that their information is not shared with other entities. Their information is only shared internally for purposes such as informing the member about programs they can take advantage of and cost savings opportunities.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.

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| **Calls Not Made by Live CCR (OTHER)** |

**REASON** The member is dissatisfied that calls are not made by live Customer Care Representatives.

**ACTION** The member was educated that the Plan uses a secured Interactive Voice Response system to communicate with members to ensure they receive information in an efficient and timely manner.

Outbound IVR system messages are used when a large number of members are required to receive the same message or when the message needs to be communicated in a timely manner to the member.

Due to the automation and volume of mail orders that process each day, some order alerts can only be communicated via the IVR system.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The member understood that if they have a question or concern regarding an IVR system message, they can contact Customer Care and a representative will be happy to explain the content of the IVR system message.

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| **Caller ID (OTHER)** |

**REASON** The member is dissatisfied with the way the Plans name is displayed on their caller ID.

**ACTION** The member was educated that outbound calls are placed by an Interactive Voice Response system specializing in healthcare communications. The Caller Identification for the IVR system is set to display CVS Caremark. However, the display can be affected depending on the type of line, analog vs. digital, the phone carrier, and landline vs. mobile phone. Furthermore, the Plan does not control all the phone carrier vendors.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The member may contact Customer Care at the phone number provided on the back of their ID card any time they receive an automated call or have any questions regarding the content of the IVR system message.

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| **Outbound Interactive Voice Response (IVR) Pin Number (OTHER)** |

* REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.
* **REASON** The member is dissatisfied that the Interactive Voice Response system provided a pin number instead of the drug information.

**ACTION** The member was educated that the Plan uses a secured IVR system to communicate with members to ensure they receive information in an efficient and timely manner. Information received via the IVR system is compliant with federal and state laws regarding Protected Health Information. If an answering machine is reached, a message is left with a toll free number to contact the Plan and a Personal Identification Number for the member to use. The PIN is a unique internal identifier number designed to not reveal PHI. Once the toll free number provided in the message is utilized, the personalized PIN will be requested to better identify the member. The member may also contact the Plan 24 hours a day, 7 days a week at the phone number on the back of their ID card at which time a personalized PIN will not be required.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.

* **If the member requested to update their messaging preference:**

Per the members request, their messaging preference was updated to be notified via **TEXT OR**  **EMAIL**.

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| **Inbound IVR Dissatisfaction (OTHER)** |

**REASON** The member expressed dissatisfaction with the Interactive Voice Response system.

**ACTION** No CCR action required.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan provided useful tips when using the IVR. The Plan recommended that the member keep background noise to a minimum, saying zero instead of the letter O. The Plan further suggested that the member avoid the use of speakerphone when interacting with the IVR and to speak directly into the phones receiver when responding to each question. If using a cell phone, the IVRs ability to understand the members responses may vary based on coverage area and signal strength.

When contacting the IVR, the system will say to the member, Tell me how I may help you. At this time, the member can offer a brief description of what they need help with or simply say, Representative. The IVR will then ask for their Date of Birth. The member can provide this or repeat the word representative to be connected with a representative who can further assist them.

To protect the privacy of a member, the Plan must authenticate a call when using the IVR. At times, the member may enter information into the IVR that is not translated fully processed in the main system. For the members protection, the Customer Care Representative may have to ask the member to repeat their information in order to ensure they are speaking to the correct member.

Members are encouraged to have a phone number on file to ensure the IVR system recognizes them when calling. The member may update the phone number on file at any time by contacting Customer Care at the number on the back of their identification card.

The Plan monitors many factors of the IVR system and invests in the continuing improvement in the IVR system. The feedback received helps to isolate issues with the IVR system that need to be reviewed and updated.

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| **Hold Music (OTHER)** |

**REASON** The member expressed dissatisfaction with the hold music.

**ACTION** The Plan endeavors to keep hold times and transfers to a minimum, but it depends on the complexity of an issue and who can resolve the issue.

**RESULT** The Plan advised that at times, it is necessary to place members on hold during a call so research can be performed or to consult with another department to resolve the issue. The member may also need to be transferred to a different department who can specialize in resolving the issue, however, the member will be placed on a brief hold during the transfer.

The Plan apologized for any dissatisfaction this may have caused. To avoid long wait times, it is recommended to call during non-peak hours such as early in the morning or in the evenings.

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| **Dissatisfaction with Outbound IVR** **System/Text Message/Email Not Providing Medication Name, Strength, or Quantity (OTHER)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction with the **SELECT APPLICABLE: IVR SYSTEM/TEXT MESSAGE/EMAIL** not providing the drug name, strength, or quantity.

**ACTION** The Plan does not know who may pick up the phone call or see the message, therefore, no medical information will be provided without the members expressed permission.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The Plan advised the member that the Health Insurance Portability and Accountability Act provides data privacy and security provisions for safeguarding medical information, including medication specific information. The Plan advised the member that if they want to receive the name of the drug they can elect to receive messages via email.

**If the member wants to update their preference to email:**

ThePlan changed the members CMP alerts email to include the drug specific information per the members request.

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| **IVR Providing Information in Spanish (OTHER)** |

**REASON** The member expressed dissatisfaction that the Interactive Voice Response system was providing information in Spanish.

**ACTION** The Plan has confirmed that the members language preference is set to English.

**Or if the language preference is set to Spanish**

**ACTION** A request has been submitted to update the members language preference to English.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The Plan educated the member that Plans are required to provide alternate language services when five percent or more of their membership speaks an alternate language. Since more than five percent of the Plans membership speaks Spanish, the IVR must provide the option to speak in Spanish.

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| **Difficulty Ordering Drugs on caremark.com (OTHER)** |

**REASON** The member expressed dissatisfaction with the difficulty of ordering drugs on caremark.com.

**ACTION** The member was educated on how to order or renew prescriptions online. When ordering or renewing drugs on the Plans website, go to the Prescription tab, click view or refill all prescriptions, click add to cart next to the prescription available for refill or Renewal, then click view cart when all required prescriptions have been added to cart, finally go to check out to review and place the order.

**RESULT** The Plan apologized for any inconvenience this may have caused. The Plan confirmed that there are no issues with the website and it is functioning accordingly. The member was encouraged to contact Customer Care for any future inquiries they may have.

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| **PHARMACY** |

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| **Professional Service (PPS) Codes (PHARMACY)** |

**REASON** The member is dissatisfied that their claim rejected due to requiring the pharmacist to enter Professional Service Codes.

**ACTION** The member was educated that the Plan conducts a drug utilization review of their prescriptions claims to ensure that benefits are being administered according to the terms of coverage, as well as ensuring the members health safety. Edits are implemented to improve control at Point of Sale and to ensure that the DUR process complies with the Centers for Medicare and Medicaid Services CMS requirements for all drug classes. A Professional Service Code is entered by a pharmacist to override the reject when applicable and to document their action for each reject.

The Plan confirmed that the members claim was successfully reprocessed and filled without a delay in medication.

**RESULT** The Plan apologized for any dissatisfaction this may have caused as this is not intended to cause an inconvenience. These alerts prompt the dispensing pharmacist to take an action that will avoid a potential safety concern. The pharmacist may consult with the prescriber, counsel the member, or choose not to fill the prescription to avoid a negative clinical outcome.

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| **Pharmacy Removed from Network (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that **PHARMACY NAME** is no longer in the Plans pharmacy network.

**ACTION** The Plan sends the member a Pharmacy Directory at the time of enrollment and annually. The member was also informed that changes to the pharmacy network may occur during the benefit year, an updated Pharmacy Directory is located on the Plans website or the member may contact Customer Care for updated provider information. A pharmacy can choose to become preferred or non preferred at any time during the year, however, most contracts are in place prior to the new plan year.

The Plan confirmed that the pharmacy is not in network.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The member was provided with a list of preferred pharmacies near their residence.

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| **Pharmacy Not Preferred Pharmacy (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that **PHARMACY NAME** is not a preferred pharmacy this year.

**ACTION** The member was educated that a preferred pharmacy has an agreement with the Plan to provide lower cost sharing. A pharmacy can choose to become preferred or non preferred at any time during the year, however, most contracts are in place prior to the new plan year.

**RESULT** The Plan apologized for any dissatisfaction this may have caused and provided the member with a list of preferred pharmacies near their residence.

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| **Pre-payment for Mail Service Orders (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png RED BOLDED TEXT** SELECT THE CORRECT **RESULT** BELOW.

**REASON** The member is dissatisfied that a payment method is required for mail service orders.

**ACTION** In order to release a prescription, a method of payment is required to be on file. The member was informed that the Plan offers the following convenient methods of payment for prescription orders Credit or Debit card, Electronic check, or regular check when ordering through the mail.

If the member does not wish to place a method of payment on file, a check or money order may be mailed prior to shipment of the order. Orders will be held until payment is received. The member also has the option to obtain their prescription via retail.

**Include for 0 dollar orders**

Although the members prescription order may be estimated as a 0.00 dollar copay, the true out of pocket cost will be determined once the order is completely processed, therefore, a method of payment is required.

**RESULT** (choose appropriate result below):

* **The Plan apologized for any dissatisfaction this may have caused. The member declined adding a payment method on file or obtaining the prescription order.**
* **The Plan apologized for any dissatisfaction this may have caused. A request was submitted to have the prescriptions transferred to the retail pharmacy per the member request.**
* **The Plan apologized for any dissatisfaction this may have caused. The member added a payment method on file and the prescription order was successfully submitted.**

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| **Refused to Fill Controlled Substance (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that **PHARMACY NAME** refused to fill **DRUG**.

**ACTION** The Plan has confirmed the drug in question is a controlled substance.

Federal and state laws impose a responsibility on practitioners, and a corresponding responsibility on pharmacists, when dispensing controlled substances. Pharmacists consider a variety of factors as part of their corresponding responsibility to appropriately fill prescriptions for controlled substances. These factors may contribute to a pharmacists decision using their professional judgment to fill or to decline to fill a controlled substance prescription.

**RESULT** The Plan supports the decision of a pharmacist to not to fill prescriptions when exercising sound professional and clinical judgment. The Plan apologized for any dissatisfaction this may have caused.

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| **Order Ineligible for Fill and Bill (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png RED BOLDED TEXT** SELECT THE CORRECT **RESULT** BELOW.

**REASON** The member is dissatisfied that their order is not eligible for Fill and Bill.

**ACTION** The member was advised that the Plan does not allow the option to have a drug mailed with an invoice instead of having a method of payment.

**RESULT** (choose appropriate result below):

* **The Plan apologized for any dissatisfaction this may have caused. The member declined adding a payment method on file or obtaining the prescription order.**
* **The Plan apologized for any dissatisfaction this may have caused. A request was submitted to have the prescriptions transferred to the retail pharmacy per the member request.**
* **The Plan apologized for any dissatisfaction this may have caused. The member added a payment method on file and the prescription order was successfully submitted.**

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| **Prescriptions Sent in Multiple Orders (PHARMACY)** |

**REASON** The member is dissatisfied that their prescriptions were sent in different orders.

**ACTION** The member was informed that prescriptions may be sent in different orders for multiple reasons such as all the prescriptions not being eligible to fill at the same time. Some prescriptions may require prescriber clarification. The mail service pharmacy will split an order so that prescriptions are not held unnecessarily while others are waiting for additional information or are not eligible for refill.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.

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| **Requesting Mail Tag (Denied) (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they received **DRUG** and is requesting to return the drug.

**ACTION** The Plan confirmed a fill request for the drug was received via **FAX, MAIL, ELECTRONICALLY, IVR, WEB, MDO PHONE, CARE**

* **If received via fax, mail, electronically, MDO phone and consent provided**

The member provided expressed ship consent for the order on **DATE**.

A mail tag postage paid address label for order return is generally approved by the Plan if it is deemed that the mail service pharmacy made an error.

**RESULT** The Plan explained to the member how the order was received, therefore, their request to return the drug was denied because it was dispensed as prescribed by the doctor and was requested by, or consented to by the member. Mail service policy does not allow the return of drug for credit if there is no evidence of a plan or dispensing error. The Plan apologized to the member for any dissatisfaction this may have caused.

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| **Requesting Mail Tag (Approved); Consent Not Provided (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they received **DRUG** and is requesting to return the drug.

**ACTION** The Plan confirmed a fill request for the drug was received from their prescriber.

A mail tag, postage paid address label for order return, is generally approved by the Plan if it is deemed that the mail service pharmacy made an error. The mail tag process provides the member with a convenient way to send drugs back to CVS Caremark Mail Service Pharmacy. If a mail tag is issued, the member should receive it within 10 to 15 days via mail. If an electronic mail tag is issued, the member should receive it within three business days via email. Members must send back any returns with the full amount dispensed and with the original prescription label. Once the returned drug is received, the members method of payment is credited within five business days.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. A mail tag was issued for the aforementioned order.

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| **Retail Pharmacy Issues (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied with **PHARMACY NAME** because **REASON**.

**ACTION** The Plan contacted the pharmacy and spoke with a pharmacy representative regarding the members concerns and requested that they be addressed with the Pharmacy Manager. The pharmacy representative advised **CALL SUMMARY**.

**RESULT** The Plan relayed the information to the member and apologized for any inconvenience or frustration the member experienced. The member was additionally provided with a list of retail pharmacies near their residence.

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| **Pharmacy Network Dissatisfaction (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction with the pharmacy network.

**ACTION** The Plan sent the member a Pharmacy Directory. A review of the members account confirmed they utilize the **PHARMACY NAME**, which is a **PREFERRED PHARMACY** or **NON PREFERRED PHARMACY**.

The Pharmacy Directory informs the member which of the pharmacies in their network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs. The member may go to either type of network pharmacy to receive their covered prescription drugs.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan provided the member with three preferred pharmacies in their area.

The Plan also advised of the mail service pharmacy where additional savings can be obtained for maintenance drugs obtained in a 90 day supply. This service is useful in areas where there is no retail pharmacy that provides preferred cost sharing.

The member was advised they can obtain a current list of pharmacies on the plans website or call Customer Care 24 hours a day, seven days a week. Customer Care can also assist with the transfer of prescriptions from one pharmacy to another.

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| **Dissatisfaction with Mail Service Consent Process (PHARMACY)** |

**REASON** The member expressed dissatisfaction with having to provide consent for prescriptions filled at the mail service pharmacy.

**ACTION** The Centers for Medicare and Medicaid Services established a guidance that mail service pharmacies must obtain and document Expressed Ship Consent from members on all newly received prescriptions prior to shipping them. This includes orders initiated by prescriber faxes, prescriber phone, and electronically submitted prescriptions. Expressed Ship Consent is not required when the member initiates the order by mail, Interactive Voice Response IVR system, Customer Care, or web portal Caremark.com. The guideline was established to make sure that the member receives only those drugs they actually need.

CVS Caremark Mail Service Pharmacy policy is to ship prescription orders without the member consent in certain circumstances. Under the modification, the member is only required to provide Expressed Ship Consent for their first order filled at the mail service pharmacy. If the member has filled a previous prescription at the mail service pharmacy during the past year under their current plan, they are no longer required to provide Expressed Ship Consent. If the member account currently requires Expressed Ship Consent for all orders, the member may request to turn off Expressed Ship Consent by contacting Customer Care.

**RESULT** The Plan apologized for any inconvenience caused by the consent process. This policy assures only prescriptions needed by the member is sent and charged to them. To avoid the consent process, the member has the option to mail all prescriptions to the pharmacy, instead of having their prescriber send the prescription, as these orders are considered to be member initiated.

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| **Order Delayed Due to Ship Consent - No Plan Error (PHARMACY)** |

**REASON** The member expressed dissatisfaction that due to ship consent, their prescription order was delayed.

**ACTION** The member is required to provide Expressed Ship Consent for their first order filled at the mail service pharmacy under their current plan.

The Plan attempts to obtain the members Expressed Ship Consent for prescription orders via their preferred method of communication. If the member cannot be reached or does not provide consent, a notification letter is sent explaining the ship consent process, and how to order.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The member was informed that the Plan attempted to obtain Expressed Ship Consent for the prescription order via their preferred method of communication. The Plan has confirmed that there was no error in processing or shipping the prescription order. The member was advised that if they would like to change their notification preferences, they can do so anytime by contacting Customer Care.

The member was additionally informed that a refill request will ship within two business days, new prescriptions will ship within five business days. However, if the new prescription or refill request requires Expressed Ship Consent, this may require an additional three to five business days to process from when consent is received. Theses turnaround times do not include delivery time to their door. For an additional fee, the member can request overnight or expedited shipping. Overnight and two day service does not include weekend and holiday delivery.

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| **Prescription Not Enrolled in Automatic Refill Program (ARP) - No Plan Error (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that theirprescription**s** **WAS OR WERE** not enrolled in the Automatic Refill Program as requested.

**ACTION** The Automatic Refill Program allows members to receive prescription refills and renewals of maintenance drugs automatically. Members can enroll their prescriptions for common maintenance drugs to automatically process and ship when the refill date is reached and or allows the mail service pharmacy to automatically reach out to the prescriber to obtain a prescription renewal when the original prescription expires or is out of refills. Certain drugs such as controlled substances, specialty drugs, and others are excluded from enrolling in the program. In order for a prescription to be enrolled in ARP, the prescription must be valid, such as have remaining refills and cannot be expired at the time of enrollment. If the prescriber sends in a new prescription prior to being contacted for a renewal, it will not be automatically enrolled into the ARP.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. **The Plan has confirmed that this is the members initial contact with the Plan requesting to enroll their prescriptions in the ARP.** To enroll prescriptions in ARP the member can either call Customer Care or enroll the prescription on the Plans website at their convenience.

**If member wants to enroll prescriptions into ARP on the call:**

The following prescriptions were enrolled in ARP

**LIST NAME OF PRESCRIPTIONS**

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| **Prescription Not Eligible for the Automatic Refill Program (ARP) (Controlled Substance) (PHARMACY)** |

**REASON** The member expressed dissatisfaction that their prescription is not eligible for the Automatic Refill Program.

**ACTION** The Automatic Refill Program allows members to receive prescription refills and renewals of maintenance drugs automatically. Members can enroll their prescriptions for common maintenance drugs to automatically process and ship when the refill date is reached and or allows the mail service pharmacy to automatically reach out to the prescriber to obtain a prescription renewal when the original prescription expires or is out of refills.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The member was informed that the ARP is available for common maintenance drugs, such as those that are taken for chronic conditions or for long term therapy. Unfortunately, controlled substances are not eligible for the ARP as federal and state laws may impose refill or renewal restrictions.

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| **Prescription Not Eligible for the Automatic Refill Program (ARP) (No Refills/Expired) (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that theirprescription is not eligible for the Automatic Refill Program.

**ACTION** The Automatic Refill Program allows members to receive prescription refills and renewals of maintenance drugs automatically. Members can enroll their prescriptions for common maintenance drugs to automatically process and ship when the refill date is reached and or allows the mail service pharmacy to automatically reach out to the prescriber to obtain a prescription renewal when the original prescription expires or is out of refills.

The member was informed that in order for a prescription to be enrolled in the automatic refill component, the prescription must have remaining refills after the prescription has been filled for the first time. In order for a prescription to be enrolled in the automatic renewal component, the prescription must be valid, such as have remaining refills and cannot be expired at the time of enrollment.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The Plan has confirmed the prescription **HAS NO REMAINING REFILLS OR IS EXPIRED**.A new prescription request was submitted via FastStart.

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| **Receives Too Many Phone Calls/Text Messages/Emails for Orders (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that they are receiving too many **SELECT ALL APPLICABLE PHONE CALLS****/TEXT MESSAGES/EMAILS** for prescription orders.

**ACTION** The member has the option to have their messaging preferences set to phone call, email and or text alert.

**RESULT** The Plan apologized to the member for any dissatisfaction this may have caused. The member can enroll in multiple messaging preference channels. This provides more flexibility to deliver the most effective message in the best method for the member. For example, a lower priority informational message can be sent by email and a higher priority message requesting the member to take action can be sent via text. CMP reviews the communication channels a member is enrolled in and will pick the best method to send that specific message. If the member opts out of CMP alerts, they may still receive required telephone calls such as high copay alert notifications.

**If messaging preference was updated include:**

Per the members request, their messaging preference was updated to **METHOD**.

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| **Received Correct Drug but Different Size or Color (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that **DRUG** looks different from the previous fill.

**ACTION** The Plan has confirmed that the previous fill for the drug was manufactured by **MANUFACTURER** and the new fill for the drug was manufactured by **MANUFACTURER**. Although the same drug and strength, the appearance, size, shape, and color of the drug may differ from manufacturer to manufacturer.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The member or prescriber may request that a generic from a specific manufacturer be dispensed, as the pharmacy may carry drugs with many different manufacturers. The prescriber should write the name of the manufacturer on the prescription. The pharmacy will make every attempt to meet the members needs. If a specific manufacturer is not covered under the Plan, a member may choose to pay out of pocket or a suitable alternative can be requested from the prescriber.

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| **Dispense As Written (DAW) Requirements (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that theirprescription was not filled for the brand name drug.

**ACTION** The prescriber writes a Dispense as Written indication on a prescription whenever they want to specify what the pharmacist must dispense to the member. DAW indications are generally written to override generic drugs with the brand name and vice versa. DAW indications are also used by the prescriber to accommodate drug preferences requested by the member. A prescription written as DAW1 indicates that the prescriber has determined the brand name drug is medically necessary to treat the members condition, and therefore lets the pharmacist know not to dispense a generic equivalent, a prescription written as DAW2 indicates that the member requested the brand name drug only. For prescriptions written without a DAW indication, the pharmacist is permitted to dispense a generic substitute.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The Plan has confirmed the prescription for **DRUG** was written without a DAW indication, therefore allowed for a generic equivalent. The member was advised to consult with the prescriber in regard to obtaining future prescriptions with a DAW indication.

**If request submitted to fill the prescription for brand per member request include:**

The Plan submitted a request to process the remaining fills of the prescription with a DAW2 indication.

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| **Prescription Not Processed with a DAW5 Indication (if Plan Allows for DAW5) (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that they were responsible for the brand name copay for **DRUG**, rather than the generic copay as the previous fill.

**ACTION** Prescriptions processed with a DAW 5 indication will be dispensed for the brand name drug and priced as the generic drug based on the Plan design. A DAW 5 indication must be used when the prescriber has indicated, in a manner specified by applicable law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity, there are several reasons a pharmacy would use a brand name drug as a generic.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.A review of the prescription for the previous fill of the drug confirms the prescription was written without a DAW indication, which allowed for the generic equivalent to be dispensed. However, the prescription was processed with a DAW 5 indication. The member obtained the brand name drug but was responsible for the corresponding generic copay.

The new prescription was written as DAW 1, which does not allow for the generic equivalent to be dispensed, therefore, the prescription was dispensed for the brand name drug and the member was responsible for the corresponding brand name copay.

The Plan advised that although a new prescription without a DAW indication is received, this does not guarantee the prescription will be processed with a DAW 5 indication.

**If applicable include:**

The member was advised that a Tier Exception can be requested for the drug.

**If applicable, include:**

**A TIER EXCEPTION REQUEST WAS SUBMITTED.**

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| **Unable to Read Prescription Labels (PHARMACY)** |

**REASON** The member expressed dissatisfaction with the prescription labels.

**ACTION** The member was advised that CVS Caremark Mail Service Pharmacy utilizes three different sized prescription labels and may provide a variety of prescription labels on a product depending how the drug is dispensed. Additionally, depending on the product and or the location it was dispensed, the prescription labels may be applied in a different way, such as being applied around the product or applied with a flag through automation not adhered to the product on both ends.

The pharmacy does not use ink to print the labels. Thermal technology prints the information using heated print heads that activate the print image on the labels. Since direct thermal printing requires heat to activate the image, it is prone to fading if exposed to external heat and or certain common household chemicals.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.The Plan informed the member about ScripTalk Station which provides those who cannot read the information on their prescriptions a safe and easy way to manage their personal healthcare, press a button, place the special Talking Label over the reader, and a pleasant natural sounding voice speaks all the information printed on the label.

**If the member requests a ScripTalk Station be mailed to them:**

Per the members request for a ScripTalk Station, the Plan can fill out the form online at www.envisionamerica.com.

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| **Upset with Packaging/Bottle Caps (PHARMACY)** |

**REASON** The member expressed dissatisfaction with the prescription order packaging.

**ACTION** The member was informed that poly bags, bubble bags and boxes are currently the only packages available at the CVS Caremark Mail Service Pharmacy.

**RESULT** The Plan apologized for any dissatisfaction this may have caused.Unfortunately, the mail service pharmacy does not offer an easy tear package for mail orders.

Although the mail service prescriptions are shipped with safety caps, the pharmacy can provide easy open caps for the standard orange bottles that we dispense. However, if the member received their drug in bottles packaged by the manufacturer, we cannot provide easy open caps. Non childproof Easy Open caps can be requested by contacting Customer Care. The caps are the easy twist off type. These caps are not the ones that convert from child proof to easy open, they are simply twist on and twist off. Snap off caps are not available. The Plan educated the member to save and reuse these caps for future orders.

**If requested include:**

The Plan requested caps to be mailed to the member.

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| **Bottle Size Too Big or Too Small (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction with the size of the prescription bottles as they are too **BIG OR SMALL**.

**ACTION** The member was advised that most prescriptions are filled using automated pharmacy equipment.

**RESULT** Among many cost saving benefits of automated pharmacy systems, it also gives the pharmacy the ability to fill more prescriptions in less time to ensure orders are received as soon as possible. The automated equipment employs only one bottle size. The mail service pharmacy is doing so to improve efficiency in filling orders. The Plan apologized for any dissatisfaction this may have caused.

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| **Refill Date Missing from Label (PHARMACY)** |

**REASON** The member expressed dissatisfaction with the refill date is missing from the prescription label.

**ACTION** The member was advised that the CVS Caremark Mail Service Pharmacy labels do not provide the refill or next order date. This decision was made to prevent inaccuracies due to unforeseen changes in time sensitive prescription drugs, prescription quantity, or the prescription itself. Additionally, CVS Caremark Mail Service labels more closely reflect labels of retail pharmacies. At retail pharmacies, the number of refills available is provided but not the specific date for the next refill.

**RESULT** The Plan suggested enrolling eligible prescriptions in the Automatic Refill Program ARP. The Plan apologized for any dissatisfaction this may have caused.

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| **Unable to Cancel Order (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that they were unable to cancel their prescription order that is in process at the CVS Caremark Mail Service Pharmacy.

**ACTION** The Plan advised that a request to cancel a prescription order can only be honored if the request is submitted prior to the order being in Label Printed, Dispensed, Packed or Metered status. Unfortunately, the prescription order is in **ORDER STATUS** status, therefore a cancellation request cannot be guaranteed. The Plan will apologize for any dissatisfaction this may have caused.

**RESULT**

**If requesting to return member initiated order include:**

The prescription order is ineligible for a mail tag postage paid address label for order return as the prescription**s ARE or IS** being dispensed as prescribed by the doctor and **WERE OR WAS REQUESTED OR CONSENTED** by the member. Mail service pharmacy policy does not allow the return of drug for credit if there is no evidence of a plan or dispensing error.

**If requestingto return non-member initiated order include:**

The mail tag postage paid address label for order return process provides the member with a convenient way to send the drug back to CVS Caremark Mail Service Pharmacy. The member should receive the mail tag via mail within 10 15 days. The members must send back any returns with the full amount dispensed and with the original prescription label. Once the returned drug is received, the members method of payment will be credited within five business days.

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| **Excluded Provider – Unable to Fill Prescriptions (PHARMACY)** |

**REASON** The member expressed dissatisfaction with not being able to fill prescriptions because their prescriber is excluded from participating in the Medicare program.

Medicare plans are prohibited from making payment for prescriptions prescribed by a medical practitioner who is excluded from Medicare by the Department of Health and Human Services Office of Inspector General.

**ACTION** Plan educated the member that they may go to another prescriber to obtain a new prescription and then have it filled at any network pharmacy, retail or mail order. The member can contact Medicare at 1.800.MEDICARE or [www.medicare.gov](http://www.medicare.gov) to locate an alternative prescriber who is covered by Medicare.

The member also has the option to pay out of pocket, without using their Part D prescription drug coverage. If the member decides to pay out of pocket, they will not be reimbursed under Medicare or their Part D prescription drug plan. The cost of the drug will not be included as part of their total drug cost or their True Out of Pocket costs.

**RESULT** The Plan apologized for not being to fill their prescriptions at this time. Information regarding the members State Health Insurance and Assistance Program was provided to assist the member in finding other resources to obtain their prescriptions.

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| **GLP-1 Drug No Longer Able to be Filled at Mail Order (PHARMACY)** |

REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that **DRUG** is no longer able to be filled at the CVS Caremark Mail Service Pharmacy when it was filled previously.

**ACTION** The member was informed that as of 05.15.2024, all doses and strengths of certain Glucagon like peptide GLP1 drugs such as Mounjaro, Trulicity, Wegovy, and Saxenda will no longer be available to be filled through the CVS Caremark Mail Service Pharmacy.

**(choose appropriate action below):**

The Plan confirmed that the member was sent a letter notifying them of this change and that their GLP1 drug could not be filled at the mail service pharmacy.

**OR**

The Plan advised the member that they will receive a letter advising of this change prior to their next scheduled available refill date.

**RESULT** The Plan advised the member to contact their local in network retail pharmacy to check their availability or speak with their prescriber about alternative therapies. The Plan apologized for any dissatisfaction this may have caused.

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| **Order Delayed Due to Exceeding the High Copay Limit - No Plan Error (PHARMACY)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that due to a high copay hold, their prescription order was delayed.

**ACTION** The member was advised that for mail service orders with a high copayment, an automated Interactive Voice Response IVR call is placed to the member regarding the high copayment amount. The member is informed the order needs their attention and instructs them to contact Customer Care for assistance. The purpose of the call is to ensure the member is aware of the high cost and willing to pay it before their method of payment on file is charged. The call provides the member an opportunity to reconsider a lower day supply of the medication, or to consult with their prescriber for lower cost alternatives, etc. An email notification may be sent to the member as well to inform them of the copay amount.

In the event the member does not answer the IVR call, a message will be left requesting the member contact Customer Care regarding the order.

If the member does not respond to the IVR call, the order is placed on indefinite hold.

The order will be auto resolved and an IVR call will not be placed in the following scenarios

If the members copay is within 50.00 of the last copay amount for the same medication.

Member initiated prescriptions IVR, CSR, and Web where the order is less than 1,000.00 and a method of payment is on file.

Prescriber initiated prescriptions or member initiated prescriptions received by mail where the prescription is less than the cardholder limit.

If the Customer Care Representative CCR places an alert specifying that the payment is approved.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The member was informed that the Plan attempted to obtain payment consent for the prescription order via an **IVR CALL AND/OR EMAIL NOTIFICATION**. The Plan has confirmed that there was no error in processing the prescription order. The member approved the payment and the prescription order was successfully submitted.

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| **Order Delayed Due to Exceeding the Cardholder Limit - No Plan Error (PHARMACY)** |

**NOTE:** This scenario is driven by non-member-initiated orders where a default method of payment is not designated, or the member’s method of payment is denied, and the copay exceeds the Cardholder Limit. This also includes prescriptions enrolled in ARP. We will not send out any prescription that would put the member’s total outstanding balance over the Cardholder Limit.

**REASON** The member expressed dissatisfaction that due to a cardholder limit hold, their prescription order was delayed.

**ACTION** The member was advised that for mail service orders with a cardholder limit, an automated Interactive Voice Response IVR call is placed to the member regarding needing a method of payment to apply to the amount of the order. The member is informed the order needs their attention and instructs them to contact Customer Care for assistance.

In the event the member does not answer the IVR call, a message will be left requesting the member contact Customer Care regarding the order.

If the member does not respond to the IVR call, the order is placed on indefinite hold.

The order will be auto resolved and an IVR call will not be placed in the following scenarios

If the members copay is within 50.00 of the last copay amount for the same medication.

Member initiated prescriptions IVR, CSR, and Web where the order is less than 1,000.00 and a method of payment is on file.

Prescriber initiated prescriptions or member initiated prescriptions received by mail where the prescription is less than the cardholder limit.

If the Customer Care Representative CCR places an alert specifying that the payment is approved.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The member was informed that the Plan notified the member of the Cardholder Limit hold via an IVR call. The Plan has confirmed that there was no error in processing the prescription order. The member provided a method of payment and the prescription order was successfully submitted.

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| Claim did not Process Through the Medicare Prescription Payment Plan After Opting in (PHARMACY) |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they had to pay their cost share to **PHARMACY NAME** for **DRUG** due to it not processing through the Medicare Prescription Payment Plan after opting-in.

**ACTION** Plan records show that the pharmacy did not process the claim under the Medicare Prescription Payment Plan.

**(choose appropriate action below):**

* **The Plan confirmed that the claim processed after the member opted into the Medicare Prescription Payment Plan however, their status was not yet updated at the time. The Plan advised that this process may take up to 24 hours to reflect in Plan systems.**

**The Plan contacted the pharmacy and spoke with a pharmacy representative regarding the members concerns and requested that they be addressed with the Pharmacy Manager. The pharmacy representative advised CALL SUMMARY.** **The Plan provided the Coordination of Benefits information to the pharmacy for reprocessing under the Medicare Prescription Payment Plan. The pharmacy confirmed the claim was processed under the Medicare Prescription Payment Plan with a 0.00 cost share.**

* **The Plan confirmed that the claim processed prior to the member opting into the Medicare Prescription Payment Plan therefore, it is not eligible for the Medicare Prescription Payment Plan.**

**RESULT** The Plan relayed the information to the member and apologized for any inconvenience or frustration the member experienced. The member was additionally provided with a list of retail pharmacies near their residence.

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| **PREMIUM BILLING** |

Refer to [Compass MED D - How to File a Grievance in Compass for Health Plans, JE (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) for further information.

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| **Issue Paying Premium through the IVR (PREMIUM BILLING)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they are having issues paying their premium through the Interactive Voice Response IVR system.

**ACTION** Premium payments, balances, refund, statement requests, etc. are some of the many self service options the IVR offers. The member was educated that to pay their monthly premium they can call the number on their premium invoice. The Plan advised that the member is unable to make a premium payment through the IVR when calling the number on the back of their card; however, they can request to speak with a Customer Care Representative when calling the number on the back of their card to make a payment over the phone.

If the member is having any difficulties, they can say Representative or press 0 at any time to be transferred to a Customer Care Representative who can further assist them.

**If payment made at the time of the call** At the time of the call, the member made a premium payment of **AMOUNT**.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. Enhancements are continuously made to the IVR system in an effort to improve the members experience and to increase available self-service options. The member was additionally provided with alternate payment methods for their monthly premium.

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| **Premium Payment Option on Caremark.com Not Available (PREMIUM BILLING)** |

REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that they are unable to make a premium payment online at Caremark.com.

**ACTION** The members monthly premium is **AMOUNT**. The members premium payment election is direct billing via invoice.

The members last payment was on **DATE** in the amount of **AMOUNT**.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan educated the member that the option to pay their premium payment on Caremark.com does not currently exist. The Plan also educated the member of the following alternate payment methods:

1 Automatic deduction from Social Security Administration benefit

2 Recurring or one-time payment via debit or credit card

3 Electronic fund transfer from a bank account

4 One-time payment via phone through a checking or savings account

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| **Payment Plan Not Set Up Yet (Set Up at Time of Call) (PREMIUM BILLING)** |

**** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their payment plan has not been set up.

**ACTION** The Plan informed the member that a payment plan cannot be set up for automatic payments, can only be accepted for a minimum of at least 10 dollars in addition to the monthly premium, and must be requested prior to their dunning disenrollment date, disenrolled members must pay the entire past due balance prior to being considered for re enrollment.

The Plan confirmed this is the members initial valid request for a payment plan.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. A payment plan was set up per their request. The member agreed to pay **AMOUNT** in addition to their monthly premium. The member current payment election is direct billing via invoice, their first payment with this payment plan will be due upon receipt of their next invoice.

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| **EFT or RCD Stopped without Request (PREMIUM BILLING)** |

**** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their **ELECTRONIC FUNDS TRANSFER DEDUCTIONS** **or REOCCURRING CREDIT OR DEBIT CARD DEDUCTIONS** were stopped without their request.

**ACTION** The member was informed that their last premium payment processed through EFT or RCD was declined. Therefore, their account was returned to direct billing via invoice.

**RESULT** (choose appropriate result below):

* **The Plan apologized for any dissatisfaction this may have caused. The member did not wish to re-enroll in automatic payments for their premium.**
* **The Plan apologized for any dissatisfaction this may have caused. The member was re enrolled in RCD per their request.**
* **The Plan apologized for any dissatisfaction this may have caused. The member can await receipt of their premium bill or print an EFT for from the Plans website and mail it to the Plan as requests for EFT deductions cannot be processed by phone.**

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| **Multiple Attempts to Set Up EFT (PREMIUM BILLING)** |

**REASON** The member is dissatisfied that their premium payment election has not been set up for Electronic Funds Transfer.

**ACTION** The member was informed that EFT can take up to two billing cycles for this automatic payment option to take effect. The member can check the EFTbox on the front of the premium invoice coupon received and sign the back of the coupon to initiate EFT deductions. The member must complete all the required information including their signature and a voided check with the request. The member can also request EFT by calling Customer Care.

* **If previous requests received:**

The Plan confirmed that their previous requests received were incomplete.

* **If no previous requests received:**

The Plan has confirmed a request is yet to be received.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan processed an EFT request for the member.

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| **Multiple Attempts to Set Up RCD (PREMIUM BILLING)** |

**REASON** The member is dissatisfied that their premium payment election has not been set up for reoccurring credit or debit card deductions.

**ACTION** The member was informed that in order to be eligible for RCD, they cannot be enrolled in Social Security Administration deductions. The timeframe to process an RCD request is before the second business day of the month for the current processing month, the credit or debit card is charged between the 8th and 10th of the month.

The Plan has confirmed this is the members initial valid RCD request.

**RESULT** The member was enrolled for RCD payments. The Plan apologized for any dissatisfaction this may have caused.

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| **Multiple Attempts to Set Up SSA/RRB Deductions (PREMIUM BILLING)** |

**** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that their premium payment election has not been set up for **SOCIAL SECURITY ADMINISTRATION SSA DEDUCTIONS OR RAILROAD RETIREMENT BOARD RRB DEDUCTIONS**.

**ACTION** The member was informed that SSA or RRB deductions can take up to two billing cycles for this automatic payment option to take effect. Members enrolled in an Employer Group Waiver Plan and members with a temporary Medicare number are ineligible for SSA or RRB deductions.

The Plan has confirmed this is the members initial valid request for SSA or RRB deductions.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plans submitted the members request for **SSA** or **RRB** deductions. If the SSA or RRB request is approved the Social Security Administration will send a confirmation letter that will also indicate when the SSA or RRB is scheduled to start.

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| **Disenrolled but Still Receiving an Invoice (PREMIUM BILLING)** |

**** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they are still receiving an invoice although they are disenrolled.

**ACTION** The Plan has confirmed that the member was disenrolled from the Plan **EFFECTIVE**. At this time, the member has an outstanding balance of **AMOUNT** that was billed for the time of coverage.

**RESULT** Since the member had access to their benefits during the time of the billed coverage, they remain responsible for the past due amount. The member will continue to receive invoices till the owed amount is satisfied. The Plan apologized for any dissatisfaction this may have caused.

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| **Not Receiving Premium Invoice (PREMIUM BILLING)** |

**** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they did not receive a premium invoice.

**ACTION** The Plan confirmed that the members premium payment election is direct billing via invoice.

Monthly premiums are due on the 1st of each month, any payment made on or after the 1st may be reflected on the members next invoice. Premium invoices are delayed a month or two for a new enrollee until their account is set up or if a Late Enrollment Penalty is applied to ensure the LEP amount is accurately billed. If the member has a 0.00 dollar balance at the time of invoicing, a premium invoice will not be sent.

The Plan advised the member that in order to ensure that they will have a premium balance at the time of invoicing, allowing an invoice to be generated and mailed, to await receipt of the applicable months premium invoice and at that time they may send in their payment.

The members current premium balance is **AMOUNT**. Premium invoices are being generated and mailed the address on file. The member confirmed that the address is correct. If the member is not receiving premium invoices, then they will need to contact the local United States Postal Service office to ensure mail is being received and delivered.

**RESULT** The member was educated as to why they did not receive a premium invoice. The Plan apologized for any dissatisfaction this may have caused.

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| **Premium Dispute - Billed for Multiple Months (PREMIUM BILLING)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member expressed dissatisfaction that their premium invoice billed them for multiple months when they are sending in regular payments.

**ACTION** The members monthly premium is **AMOUNT**. The members premium payment election is direct billing via invoice.

The members last payment was on **DATE** in the amount of **AMOUNT**. As this payment was posted to their account after the due date, the invoice mailed to the member billed for multiple months of premiums.

**RESULT** The Plan apologized for any dissatisfaction this may have caused. The Plan advised that the premium billing cycle ends on the first day of each month. At the top of each premium invoice a statement reads, Payments received after the first day of the month may appear on your next invoice. For example, when a payment posts two days after the due date, it misses the billing cutoff date by two days. Although the invoice bills them for two months, their account is current. The Plan assured the member that when a payment is received and posted after the billing cutoff date, their account is not considered past due, nor are they charged a penalty.

The Plan advised the member to mail payments timely to ensure they are received prior to the due date. The Plan also educated the member of the following alternate payment methods:

1 Automatic deduction from Social Security Administration benefit

2 Recurring or one-time payment via debit or credit card

3 Electronic fund transfer from a bank account

4 One-time payment via phone through a checking or savings account

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| **Upset with Premium Increase (****PREMIUM BILLING)** |

**REASON** The member expressed dissatisfaction with the premium increase.

**ACTION** The Plan sent the member the Annual Notice of Changes, which provided important plan information. Members are provided with sufficient time to review any changes and decide whether the plan will continue to meet their needs in the next year. Medicare allows members to make enrollment changes during the Medicare Annual Election Period, which occurs October 15 through December 7.

**RESULT** The Plan confirmed the members premium has increased. The Plan apologized and advised the member that while the Plan uses every available resource to hold down the cost of the premiums, it is sometimes unavoidable. The Plan additionally advised the member that the Plan continually looks for innovative solutions to make prescription drug coverage more affordable to our members.

The Plan understands that the premium increase can cause members financial hardship, therefore, the Plan provided Extra Help information and encouraged the member to contact the Social Security Administration at 1.800.772.1213. If they qualify, Medicare could help pay a portion of their drug costs including monthly prescription drug premiums, annual deductibles and copays. The member can also apply for Extra Help online at the Prescription Help section of www.socialsecurity.gov.

The Plan advised the member of the State Pharmacy Assistance Program available in their state, if applicable.

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| **Premium – Dunning Process (PREMIUM BILLING)** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION.

**REASON** The member is dissatisfied that they received a potential disenrollment notice.

**ACTION** The Plan confirmed that the member was mailed **DUN1 DUNRL** notice due to no premium payment for month of **DATE**. The potential disenrollment process consists of communicating with members regarding premiums that are overdue and that must be paid within the two calendar month grace period in order to remain covered under the MED D plan. Last payment posted to account was **AMOUNT** on **DATE**. Member currently has **AMOUNT** balance.

**RESULT** (select applicable)

* The member was educated that currently **AMOUNT** is due by **DATE** to remain with the plan. The Plan apologized for any dissatisfaction this may have caused.
* The member was educated that payment of **AMOUNT** was received after the potential disenrollment notice was mailed and currently owes **AMOUNT** by **DATE**. The Plan apologized for any dissatisfaction this may have caused.

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| **When Above Templates Do Not Apply** |

**http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png** REPLACE THE **RED BOLDED CAPITALIZED TEXT** WITH THE MEMBER-SPECIFIC INFORMATION. **DO NOT** copy and paste this template into Compass. Ensure that Reason, Action, and Result are included in the notes. The following template is for use when the above templates do not apply to your Grievance issue.

**REASON THE ISSUE FOR WHICH GRIEVANCE IS BEING FILED.** **COMPLETE USING YOUR OWN WORDS USING AS MUCH INFORMATION AND DETAIL AS POSSIBLE.**

* Who did you speak to. Notate whether you spoke to anyone other than the member.
* What are they calling about.
* Notate additional comments or notes that may help the next time this member calls.
* Include background information for the members call.

**ACTION** **STEPS TAKEN TO RESOLVE THE ISSUE.** **COMPLETE USING YOUR OWN WORDS USING AS MUCH INFORMATION AND DETAIL AS POSSIBLE.**

* What happened on the call.
* Notate what actions you took during the call, i.e., Support Task created, member transferred, etc.

**RESULT** **EDUCATION PROVIDED AND OR OUTCOME OF ACTION TAKEN.** **COMPLETE USING YOUR OWN WORDS USING AS MUCH INFORMATION AND DETAIL AS POSSIBLE.**

* What was the end result.
* Notate actions taken to resolve the issue.
* Notate that an apology was provided.
* Notate what you did next if the issue was not resolved i.e., transferred call to another department.

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