**Compass MED D - Member Stories - Coverage Determination**

[Coverage Determination](#_Toc116900831)

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**Description:** Outlines the Coverage Determination process for Medicare Part D medications, detailing how members can appeal denials and the steps representatives should take to assist them. It emphasizes the importance of educating members about their coverage options and the procedures for obtaining necessary approvals.

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| **Coverage Determination** |

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| **Case Study Components** | **Case Study Focal Points** | | |
| **Relating to Coverage Determination – Real World Example** | * Credit cards are commonly used for everyday life purchases. They are sometimes considered to be a good way to take advantage of their rewards programs or to create or improve upon someone’s credit score. * After applying for your credit card, you will either get an approval outright thereafter or you may sometimes be denied for specific reasons. * When you are denied, the credit company will send you a letter detailing why you were denied. * This letter allows you to take proactive steps to correct anything standing in your way, then you can choose to reapply to see if you can now be approved. * The Coverage Determination process works similarly with medications, based on the beneficiary’s plan design allowances:   + For example, a prescription may be approved to be filled with no issues at all or it could be rejected.   + The rejection could be related to something simple, like the member is attempting to fill it in before they are approved, or it could be denied for needing a coverage approval.   + After a member goes through the coverage approval process, they will either be approved based on the additional information provided by their doctor or they could be denied again.   + If they are denied, they will get a letter detailing why and the member is entitled to appeal the denial, to try and get their medication covered. This is known as the Redetermination process. | | |
| **Beneficiary Scenario** | * **Member:** “I went to the pharmacy to pick up two of my medications, one was <drug A> and the other was <drug B> but my pharmacist said both of my meds were not covered. Can you please investigate this and help me understand what happened?” | | |
| **Initial CCR Response** | * **R****epresentative:**  <Member name>, I can understand being surprised by going to the pharmacy and being told your meds were not covered. * **Representative:**  I can absolutely look into your account though and we can determine what happened and talk everything out. | | |
| **Initial Probing Questions** | * **Representative:**  Looking at your account I’m not seeing previous fills for either medication, are these new prescriptions?   **Note:** In our scenario, the member is filling brand new prescriptions. | | |
| **Assessing the Situation (i.e., what do you know and where could it take you)** | * Always run a Test Claim to confirm the rejection reasons, using the applicable days’ supply details. * During the first quarter of the year, as part of Members using their new benefits, we will encounter expiring Prior Authorization situations. * For existing prescriptions, this may have been a Transition Fill situation. * If the rejection is tied to a Prior Authorization (PA) being needed, you will need to review the Med D CIF. Once you have confirmed that our PBM handles the CD&A, submit a Support Task to trigger the Coverage Determination process. * If the medication is rejected for non-formulary and the member wants to discuss covered formulary alternatives, assist them on all other topics and then run a test claim for alternative medication. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b). * Test Claim rejection details may indicate the medication is covered under their Part B benefits. * Always verify the Prior Authorization (PA) status on the **Override/PA History** hyperlink, it is possible the claim was run before a PA was approved, it could still be pending approval or the drug details on the claim do not exactly match the PA (**Example:**  Tab vs. cap). * Check the CIF if the rejection is for Plan Limitations. For example, they may only be able to fill for 60 days but the script is for 90 days, or they may only be allowed a specific number of fills at Retail. | | |
| **Differentiating between a Prior Authorization and Exceptions** | * All Coverage Determination situations are Prior Authorizations (PA) however not all PAs are Coverage Determination situations. * Prior Authorization examples are Step Therapy & Quantity Limits. In these situations, the drug is covered on the member’s formulary, however they must meet pre-qualifications before they can fill the initial prescription. * Coverage Determination includes the scenarios above and Formulary Exceptions & Tiering Exceptions, examples are:   + Formulary Exception (FE) is requested when a drug that is not covered on the member’s formulary and they want to get it included/covered. When needed, run a test claim for alternative medication. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b).   + Tiering Exception is requested when a drug is fully covered on the member’s formulary however the member is looking to lower the tier of the drug to make it more cost effective. | | |
| **Preparing to Educate the Member** | **Note:** These actions would be completed for both drugs.   * Run Test Claim(s) to confirm the reason(s) for the claim rejections. Refer to [Compass - Test Claims (050041](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe)) as needed.   1. Click the **Create Test Claim** button from the **Claims** table on the Claims Landing Page.   2. Process the Test Claim using today’s date.   3. View the Test Claim details. * Review the actual claim details. Refer to [Compass - Claims Landing Page (049993](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c8f0ac8f-b076-4187-944d-2cf65b0ec799)) as needed.   + Access the rejected claims by clicking the **Rx #** hyperlink from the **Claims** table on the Claims Landing Page.   + Click the **Messaging** tab to locate settlement/rejection codes and messaging.   + Confirm if the claim rejections are the same as your to-date Test Claim; if they are the same continue, but if the rejections are different (**Example:** PA vs. Refill Too Soon) access those work instructions and assist the member as needed.   Refer to:   * [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff)) * [Compass - Test Claims (050041)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe) | | |
| **Educating on the Member’s Claims (Drug A)** | **Note:** For the first drug the Test Claim & Claim Rejections reflect the same, it is rejecting for reject 76, which is Quantity. For Quantity situations the prescription is exceeding the per fill limitations.  **Representative:**  I was able to determine what happened, looking in our systems your <drug name> is rejecting for Quantity Limitations.  **Representative:**  Looking at your plan details & allowances, your plan only allows you to fill a 30 days’ supply of this medication; however your prescription is for 90 days.  **Note:** On your Test Claim Retail Messages column you will be provided with the plan limitations.  Refer to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff)). | | |
| **Submitting for the Prior Authorization via Support Task** | PA Request Procedural Steps:   1. Access [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff)). 2. Locate & follow the “Submitting a Support Task for CD&A” section. 3. Repeat the entire request back to the caller to confirm accuracy before submitting. 4. Educate the member on the actions you took and the expected next steps.   **Representative:**  The request for the new prescription has been submitted; you can contact your doctor to notify them that we’ll be sending them a request for a Prior Authorization for <drug name>.  **Representative:**  This takes care of your first medication, now let’s talk through what happened with your <drug name> medication.  **Note:**  As part of the discussion the member conveys dissatisfaction about having to go through the approval process. She advises the doctor to write her the prescription and knows what she should be taking. As a result, she does not agree with having to go through this. She ends with, if this is the only way to get her meds, she will follow the process. | | |
| **Educating on the Member’s Claims Drug B** | **Note:** For the second drug, the Test Claim & Claim Rejections reflect the same, the reject is for Non-Formulary (reject 70).   * **Representative:**  Based on the information I’m seeing in our systems, your <drug name> is currently not included on your plans formulary. * **Representative:**  To help you though, we can help to identify potentially covered alternatives. Would you like for me to look for alternatives? * **Member:**  Yes, that will help me, thank you. * **Representative:**  Great. Let me just take a moment to add some notes to your account on our discussion today and then I will work to identify potentially covered alternatives. | | |
| **Situational Steer Member PA Status**  **Call Backs** | When a PA coverage request has been submitted for the member, they will receive a letter advising them of the outcome, but it is also common for them to call back to request a status.   1. Access Compass. 2. Click the **Override/PA History** hyperlink from the **Quick Actions** panel on the Claims Landing Page. 3. Navigate to the **PA Status** section. 4. Confirm the status:    1. Approved    2. In Process or Pending    3. Denied    4. Cancelled 5. Educate the member on the status, any next step expectations, and the potential steps for filing an Appeal.   Refer to[Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff)) and locate the “Decision Grid” section. | | |
| **Situational Steer CD Senior Escalation scenarios** | When educating the member on the Coverage Determination (CD) request process for the non-formulary drug, you may experience push back due to them not wanting any alternatives, instead they want to speak to someone on getting their original medication covered. It is important to be aware of when the caller needs to be transferred to Seniors, please see below for overall primary reasons.   * Beneficiary is escalated and insistent on being transferred to the CD team. * Case notes indicate contacting the CD Team for more information on the request. * The beneficiary wants to withdraw a case that is open or pending. * Beneficiary calls with a change in provider/prescriber for an in-progress case. * The beneficiary is returning an outbound call from the CD Team. * Client Representatives/Benefit office wants to speak to CD on behalf of the beneficiary. | | |
| **Situational Steer Medication is covered under Part B** | **Note:**  Some examples of medications covered under Part B are Insulin that comes in pumps or injections which must be administered at their doctor’s office. To confirm, run a Test Claim on the medication and review the outcome details.  **Representative:**  Based on what I’m seeing in your account, your <medication name>medication is not covered under your Part D benefits, but it may be covered under your medical, Part B benefits.  **Notes:**   * If approved by your supervisor, you may contact the Pharmacy to have them rerun the claim under their Part B benefits. * If service levels do not allow you to make the reach out, advise the member they can contact their medical number on the back of their card to verify coverage.   Refer to [Compass - CCR - Identifying and Handling Medicare Part B Calls (061873](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c9e4cc50-c745-47e5-9df5-f145e15a8c9c)). | | |
| **Situational Steer Transition Fill situations** | A Transition Fill occurs during the first 90 days of their new plan year. This process allows the member to receive 30 days of medication which was previously covered however it is no longer covered in the new plan’s formulary.  When a member fills a medication through the Transition Fill process, they’ll receive a letter informing them they need to find an alternative medication.  When this happens, a member may call and advise them they do not understand the letter because they were able to fill the medication previously. Verify the details in the claim and educate the member accordingly on the process.  If the member would like to discuss potential covered alternatives, run a test claim for alternative medication. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b).  Refer to [Compass MED D - Transition Fill Care Processes (061926)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=15daa63f-81c8-4c0d-a02d-36481155d042). | | |
| **Filing the Applicable Grievances** | 1. Access [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, Aetna EGWP) (068896)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e" \t "_blank). 2. Access the MHK Nitro system. 3. Submit an FCR Grievance for “Physician Wrote Prescription So Additional Approval Should Not Be Necessary (CD/RD).”   **Notes:**   * Always confirm if there is an open grievance for this same issue first. * This is an FCR Grievance because the CD process will not change but we need to record our member experiences & dissatisfactions regarding having to go through the CD process. | | |
| **Anticipating Beneficiary Q&A** | Refer to the below: | | |
| **#** | **Question** | **Answer** |
| **1** | How long will it take to get a response on my Coverage Determination request? | The guidance is:   * Standard – 72 hrs., up to 17 days for any exceptions request * Expedited – 24 hrs., up to 15 days for any exceptions request   **Note:** this includes nights, weekends, and holidays |
| **2** | What can I do if my Coverage Determination request is denied? | The member has a right to Appeal the decision. |
| **3** | If I file a Redetermination, how long does it take to get a response? | The guidance is:   * 72 hrs. for expedited * 7 calendar days for standard   **Note:** this includes nights, weekends, and holidays |
| **4** | Do I have to request a Prior Authorization every year or if I get approved, is it good for as long as I take my meds? | It must be renewed annually. The length of the approval may vary based on the medication and the doctor’s approval. |
| **5** | Is it possible to have my Prior Authorization backdated? | The decision will be made by the team handling the determination; they will collaborate with your doctor to make a final determination. After the final decision is made, we will be able to provide you with the information. |
| **6** | What can be done now, I need my medication? | The member can pay out of pocket and if the Prior Authorization is approved and backdated, they can submit a paper claim for a reimbursement. If the PA is denied, they always have the right to Appeal the decision.  **Note:** Refer to [Member Cannot Afford Medication (Alternatives and Financial Assistance) (026963)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=62aa67ac-8298-4fa1-b1ba-fda383d15b4c). |
| **Compass Call**  **Documentation Notes** | Spoke with the member regarding prescription rejections at the pharmacy. For <drug A>, which was rejecting for Quantity, a PA Support Task was submitted. For <drug B> which was rejected for non-formulary, member was provided alternatives. Filed a FCR grievance since the member was dissatisfied with having to go through the Coverage Determination process, the Grievance number is <number>. | | |
| **Call Closing Recap** | **Representative:**  To make sure we took care of everything today; we filed a Coverage Determination request for <Drug A> and helped you identify potential alternatives for <Drug B>. | | |
| **Call Closeout& Survey Awareness** | **Representative:**  Thank you for calling, please be aware you may receive a survey via e-mail in the next day or two regarding your call experience today.  **Note:** the beneficiary can opt out of the survey through a link within the e-mail invite.  Refer to  [Universal Care - Consultative Call Flow (CCF) Process (095822)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c954b131-7884-494c-b4bb-dfc12fdc846f). | | |

[Top of the Document](#_top)

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| **Related Documents** |

* [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff))
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* [Universal Care - Consultative Call Flow (CCF) Process (095822)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c954b131-7884-494c-b4bb-dfc12fdc846f)

[Top of the Document](#_top)

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