# Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, Aetna EGWP)

[Reminders](#_Toc193378219)

[ACCESS](#_Toc193378220)

[Pharmacy is Excluded from the Medicare Program (ACCESS)](#_Toc193378221)

[Excluded Provider – Unable to Fill Prescriptions (ACCESS)](#_Toc193378222)

[Pharmacy Removed from Network (ACCESS)](#_Toc193378223)

[Order Delayed Due to Ship Consent - No Plan Error (ACCESS)](#_Toc193378224)

[Dispense As Written (DAW) Requirements (ACCESS)](#_Toc193378225)

[Prescription Not Processed with a DAW5 Indication (if Plan Allows for DAW5) (ACCESS)](#_Toc193378226)

[Medications Sent in Multiple Orders (ACCESS)](#_Toc193378227)

[Requesting Mail Tag (Denied) (ACCESS)](#_Toc193378228)

[Requesting Mail Tag (Approved); Consent Not Provided (ACCESS)](#_Toc193378229)

[GLP-1 Drug No Longer Able to be Filled at Mail Order (ACCESS)](#_Toc193378230)

[BILLING](#_Toc193378231)

[Premium Dispute - Billed for Multiple Months (BILLING)](#_Toc193378232)

[Premium Payment Plan Not Set Up Yet (Set Up at Time of Call) (BILLING)](#_Toc193378233)

[EFT or RCD Stopped without Request (BILLING)](#_Toc193378234)

[Multiple Attempts to Set Up EFT (BILLING)](#_Toc193378235)

[Multiple Attempts to Set Up RCD (BILLING)](#_Toc193378236)

[Multiple Attempts to Set Up SSA/RRB Deductions (BILLING)](#_Toc193378237)

[Issue Paying Premium at the Pharmacy (BILLING)](#_Toc193378238)

[Issue Paying Premium through the IVR (BILLING)](#_Toc193378239)

[Issue Paying Premium via Payment Portal (BILLING)](#_Toc193378240)

[CMS ISSUES](#_Toc193378241)

[Unable to Use Coupon with Plan Benefits (CMS ISSUES)](#_Toc193378242)

[Low Income Subsidy (LIS) Copay Dissatisfaction (CMS ISSUES)](#_Toc193378243)

[Dissatisfaction with Mail Service Consent Process (CMS ISSUES)](#_Toc193378244)

[CD/RD](#_Toc193378245)

[Not Notified of Expiring Coverage Determination (CD/RD)](#_Toc193378246)

[Physician Wrote Prescription So Additional Approval Should Not Be Necessary (CD/RD)](#_Toc193378247)

[Having to File Coverage Determination Annually (CD/RD)](#_Toc193378248)

[CUSTOMER SERVICE](#_Toc193378249)

[Plan Unable to Fax or Email Information (CUSTOMER SERVICE)](#_Toc193378250)

[Upset with Being Contacted by the ADT Program (CUSTOMER SERVICE)](#_Toc193378251)

[Long Hold Time (to Reach a CCR) (CUSTOMER SERVICE)](#_Toc193378252)

[Long Hold Time (Placed on Hold by CCR) (CUSTOMER SERVICE)](#_Toc193378253)

[Call Disconnected (CUSTOMER SERVICE)](#_Toc193378254)

[Multiple Transfers During Call (CUSTOMER SERVICE)](#_Toc193378255)

[Authentication Process (CUSTOMER SERVICE)](#_Toc193378256)

[Offshore Customer Care Sites (CUSTOMER SERVICE)](#_Toc193378257)

[Receives Too Many Phone Calls for Orders (CUSTOMER SERVICE)](#_Toc193378258)

[Received Correct Medication but Different Size or Color (CUSTOMER SERVICE)](#_Toc193378259)

[Unable to Cancel Order (CUSTOMER SERVICE)](#_Toc193378260)

[ENROLL/DISENROLL](#_Toc193378261)

[CMS Facilitated Their Enrollment into Part D Plan Against Their Wishes (ENROLL/DISENROLL)](#_Toc193378262)

[CMS Auto-Enrolled Into Part D Plan Against Their Wishes (ENROLL/DISENROLL)](#_Toc193378263)

[Dissatisfied with Disenrollment Process (ENROLL/DISENROLL)](#_Toc193378264)

[Received Multiple Residence Verification Forms (RVF) (ENROLL/DISENROLL)](#_Toc193378265)

[Multiple Attempts to Disenroll (ENROLL/DISENROLL)](#_Toc193378266)

[Initial Enrollment Period (IEP) Effective Date (ENROLL/DISENROLL)](#_Toc193378267)

[Received RVF but did not Move (ENROLL/DISENROLL)](#_Toc193378268)

[Incorrect Address on File (ENROLL/DISENROLL)](#_Toc193378269)

[Too Much Mail (ENROLL/DISENROLL)](#_Toc193378270)

[Explanation of Benefits - Does Not Want to Receive (ENROLL/DISENROLL)](#_Toc193378271)

[Unable to Enroll Due to No Special Enrollment Period (ENROLL/DISENROLL)](#_Toc193378272)

[MARKETING](#_Toc193378273)

[Plan Materials Confusing (MARKETING)](#_Toc193378274)

[Charged Different Price than Displayed on Plan Website (MARKETING)](#_Toc193378275)

[Charged Different Price than Displayed on caremark.com (MARKETING)](#_Toc193378276)

[Dissatisfied with Telemarketing Calls (MARKETING)](#_Toc193378277)

[Price Difference Between Medicare Plan Finder and Estimated Cost/Out of Pocket Cost/Plan Website (MARKETING)](#_Toc193378278)

[MEMBER MATERIALS](#_Toc193378279)

[Disenrolled but Still Receiving an Invoice (MEMBER MATERIALS)](#_Toc193378280)

[Not Receiving Premium Invoice (MEMBER MATERIALS)](#_Toc193378281)

[Did Not Receive ID Card (MEMBER MATERIALS)](#_Toc193378282)

[Unable to Read Prescription Labels (MEMBER MATERIALS)](#_Toc193378283)

[Upset with Packaging/Bottle Caps (MEMBER MATERIALS)](#_Toc193378284)

[Bottle Size Too Big or Too Small (MEMBER MATERIALS](#_Toc193378285))

[Refill Date Missing from Label (MEMBER MATERIALS)](#_Toc193378286)

[Not Receiving Plan Materials in their Preferred Language (English/Spanish) (MEMBER MATERIALS)](#_Toc193378287)

[PLAN BENEFIT](#_Toc193378288)

[Upset with Premium Increase (PLAN BENEFIT)](#_Toc193378289)

[No Savings through Mail Service Pharmacy (PLAN BENEFIT)](#_Toc193378290)

[LIS Cost Increase Due to Level Change (PLAN BENEFIT)](#_Toc193378291)

[LIS Cost Increase Due to New Year and Previously in Catastrophic Stage (PLAN BENEFIT)](#_Toc193378292)

[Coverage Gap Dissatisfaction (PLAN BENEFIT)](#_Toc193378293)

[Overall Plan Design Dissatisfaction (PLAN BENEFIT)](#_Toc193378294)

[Tier Change Dissatisfaction (PLAN BENEFIT)](#_Toc193378295)

[Unhappy with Transition Fill Process (PLAN BENEFIT)](#_Toc193378296)

[Plan not Paying towards Medication (PLAN BENEFIT)](#_Toc193378297)

[Recoupment Process Dissatisfaction (PLAN BENEFIT)](#_Toc193378298)

[Dissatisfaction with Cost after Approved Formulary Exception (PLAN BENEFIT)](#_Toc193378299)

[Dissatisfaction with Cost Due to Deductible (PLAN BENEFIT)](#_Toc193378300)

[Dissatisfaction with Plan’s Override Policy (PLAN BENEFIT)](#_Toc193378301)

[Medication Not Covered Under Med D Law (PLAN BENEFIT)](#_Toc193378302)

[Dissatisfaction with Utilization Rate (PLAN BENEFIT)](#_Toc193378303)

[Dissatisfaction with Tier Exception Not Applicable during Coverage Gap (PLAN BENEFIT)](#_Toc193378304)

[Medication Not Eligible for Tier Exception (PLAN BENEFIT)](#_Toc193378305)

[Received Transition Fill and Not the Full Day Supply (PLAN BENEFIT)](#_Toc193378306)

[Not Aware TrOOP Started at $0 at Beginning of Plan Year (PLAN BENEFIT)](#_Toc193378307)

[Pharmacy Network Dissatisfaction (PLAN BENEFIT)](#_Toc193378308)

[Pharmacy Not Preferred Pharmacy (PLAN BENEFIT)](#_Toc193378309)

[Pre-payment for Mail Service Orders (PLAN BENEFIT)](#_Toc193378310)

[Order Ineligible for Fill and Bill (PLAN BENEFIT)](#_Toc193378311)

[Prescription Not Eligible for the Automatic Refill Program (ARP) (Controlled Substance) (PLAN BENEFIT)](#_Toc193378312)

[Prescription Not Eligible for the Automatic Refill Program (ARP) (No Refills/Expired) (PLAN BENEFIT)](#_Toc193378313)

[Prescription not Enrolled in Automatic Refill Program (ARP) - No Plan Error (PLAN BENEFIT)](#_Toc193378314)

[Professional Service (PPS) Codes (PLAN BENEFIT)](#_Toc193378315)

[PRIVACY](#_Toc193378316)

[Concerned that Information is being Shared Without Consent (PRIVACY)](#_Toc193378317)

[Received Another Beneficiary's Mail; HIPAA Violation (PRIVACY)](#_Toc193378318)

[Received Another Beneficiary’s Rx Order; HIPAA Violation (PRIVACY)](#_Toc193378319)

[PROVIDER CUSTOMER SERVICE](#_Toc193378320)

[Inappropriate Billing by Pharmacy (Claim Already Reversed) (PROVIDER CUSTOMER SERVICE)](#_Toc193378321)

[Inappropriate Billing by Pharmacy (Pharmacy Needs to Reverse Claim) (PROVIDER CUSTOMER SERVICE)](#_Toc193378322)

[Retail Pharmacy Issues (PROVIDER CUSTOMER SERVICE)](#_Toc193378323)

[Refused to Fill Controlled Substance (PROVIDER CUSTOMER SERVICE)](#_Toc193378324)

[TECHNOLOGY](#_Toc193378325)

[Dissatisfied with Functionality or Content on caremark.com (TECHNOLOGY)](#_Toc193378326)

[Calls Not Made by Live CCR (TECHNOLOGY)](#_Toc193378327)

[Caller ID (TECHNOLOGY)](#_Toc193378328)

[Outbound Interactive Voice Response (IVR) Pin Number (TECHNOLOGY)](#_Toc193378329)

[Inbound IVR Dissatisfaction (TECHNOLOGY)](#_Toc193378330)

[Hold Music (TECHNOLOGY)](#_Toc193378331)

[Dissatisfaction with Outbound IVR Not Providing Medication Name, Strength, or Quantity (TECHNOLOGY)](#_Toc193378332)

[IVR Providing Information in Spanish (TECHNOLOGY)](#_Toc193378333)

[Difficulty Ordering Medications on caremark.com (TECHNOLOGY)](#_Toc193378334)

[When Above Templates Do Not Apply](#_Toc193378335)

**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 (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81). These templates should be used **only** for documentation. These templates provide key points to summarize and address with the beneficiary. Do not read these templates word for word to the beneficiary.

The Grievance templates listed below will assist in capturing the Reason, Action, and Result for First Call Resolution Grievances.

These templates are **ONLY** to be used for First Call Resolution Grievances in Compass.



**Note:** These templates do not cover all of the possible First Call Resolution Grievance types. If a CCR receives a call from a Beneficiary 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.

Make sure to read the bolded information between the <<**symbols**>>. Within each template, there may be Beneficiary-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.

[Top of the Document](#TopOfDoc)

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| ACCESS |

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

[Top of the Document](#TopOfDoc)

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| Pharmacy is Excluded from the Medicare Program (ACCESS) |

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that the <<**PHARMACY NAME**>> is excluded from the Medicare program.

**ACTION** The beneficiary was informed that the Plan has implemented a process to check whether a pharmacy is listed as an excluded provider in databases. There are many reasons why a pharmacy may be excluded such as the pharmacy engaging in some misconduct. Claims processed by excluded pharmacies will not be accepted by the Plan.

**RESULT** The beneficiary will need to obtain their medications from a pharmacy that is not excluded or refer the pharmacy to the Office of Inspector General OIG office if excluded through the OIG database at 1 202 691 2311 or via email at [sanction at oig.hhs.gov](mailto:sanction@oig.hhs.gov). The beneficiary was provided with a list of pharmacies near their residence.

[Top of the Document](#TopOfDoc)

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| Excluded Provider – Unable to Fill Prescriptions (ACCESS) |

**REASON** The beneficiary 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 OIG.

**ACTION** Plan educated the beneficiary 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 beneficiary 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 beneficiary also has the option to pay out of pocket without using their Part D prescription drug coverage. If the beneficiary decides on this option they will not be reimbursed under Medicare or their Part D prescription drug plan. The cost of the medication will not be included as part of their total drug cost or their True Out of Pocket TrOOP costs.

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

[Top of the Document](#TopOfDoc)

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| Pharmacy Removed from Network (ACCESS) |

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** The Plan sends the beneficiary a Pharmacy Directory at the time of enrollment and annually. The beneficiary 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 beneficiary 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 beneficiary was provided with a list of preferred pharmacies near their residence.

[Top of the Document](#TopOfDoc)

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

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

**ACTION** The beneficiary is required to provide Expressed Ship Consent for their first order filled at the mail service pharmacy under their current plan. Beneficiaries who have prescriptions enrolled in the CVS Caremark Automatic Refill Program ARP service are still required to provide Expressed Ship Consent. Beneficiaries who have returned a non beneficiary initiated order are required to provide Expressed Ship Consent on all future orders.

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

**RESULT** The beneficiary 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 beneficiary was advised that if they would like to change their notification preferences, they can do so anytime by contacting Customer Care.

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

[Top of the Document](#TopOfDoc)

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| Dispense As Written (DAW) Requirements (ACCESS) |

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** The prescriber writes a Dispense as Written DAW indication on a prescription whenever they want to specify what the pharmacist must dispense to the beneficiary. DAW indications are generally written to override generic medications with the brand name and vice versa. DAW indications are also used by the prescriber to accommodate drug preferences requested by the beneficiary. A prescription written as DAW1 indicates that the prescriber has determined the brand name drug is medically necessary to treat the beneficiarys condition, and therefore lets the pharmacist know not to dispense a generic equivalent, a prescription written as DAW2 indicates that the beneficiary 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 has confirmed the prescription for <<**NAME OF MEDICATION**>> was written without a DAW indication, therefore allowed for a generic equivalent. The beneficiary was advised to consult with the prescriber to obtain future prescriptions with a DAW indication.

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

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

[Top of the Document](#TopOfDoc)

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

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that they were responsible for the brand name copay for <<**MEDICATION**>>, 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 medication as a generic.

**RESULT** 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 beneficiary 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 beneficiary 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 beneficiary was advised that a Tier Exception can be requested for the drug.

[Top of the Document](#TopOfDoc)

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| Medications Sent in Multiple Orders (ACCESS) |

**REASON** The beneficiary is dissatisfied that their medications were sent in different orders.

**ACTION** The beneficiary was informed that medications 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 not eligible for refill.

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

[Top of the Document](#TopOfDoc)

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| Requesting Mail Tag (Denied) (ACCESS) |

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that they received <<**MEDICATION>>** and is requesting to return the medication.

**ACTION** The Plan confirmed a fill request for the medication was received via <<**FAX/MAIL/ELECTRONICALLY/IVR/WEB/MDO PHONE/CARE**>>

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

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

[Top of the Document](#TopOfDoc)

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| Requesting Mail Tag (Approved); Consent Not Provided (ACCESS) |

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that they received <<**MEDICATION**>> and is requesting to return the medication.

**ACTION** The Plan confirmed a fill request for the medication 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 beneficiary with a convenient way to send drugs back to CVS Caremark Mail Service Pharmacy. If a mail tag is issued, the beneficiary should receive it within 10 to 15 days via mail. If an electronic mail tag is issued, the beneficiary should receive it within three business days via email. Beneficiaries must send back any returns with the full amount dispensed and with the original prescription label. Once the returned drug is received, the beneficiarys method of payment is credited within five business days.

The Plan educated the beneficiary that they are allowed to return one mail service order and will then be required to provide ship consent for all future orders.

**RESULT** A mail tag was issued for the aforementioned order and the beneficiarys account was updated to require consent for all future orders.

[Top of the Document](#TopOfDoc)

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

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

**REASON** The beneficiary 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 beneficiary 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 beneficiary 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 beneficiary that they will receive a letter advising of this change prior to their next scheduled available refill date.

**RESULT** The Plan advised the beneficiary 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.

[Top of the Document](#_top)

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| BILLING |

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

[Top of the Document](#TopOfDoc)

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

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** The beneficiary s monthly premium is $<<**AMOUNT**>>. The beneficiary s premium payment election is direct billing via invoice.

The beneficiary s 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 beneficiary billed for multiple months of premiums.

**RESULT** 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 beneficiary that when a payment is received and posted after the billing cut off date, their account is not considered past due, nor are they charged a penalty.

The Plan advised the beneficiary to mail payments timely to ensure they are received prior to the due date. The Plan also educated the beneficiary 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 at aetnamedicare.com

5. Payment at a retail CVS pharmacy with copy of invoice

6. One time payment via phone through a checking or savings account

[Top of the Document](#TopOfDoc)

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

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that their payment plan is yet to be set up.

**ACTION** The Plan informed the beneficiary 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 beneficiaries must pay the entire past due balance prior to being considered for re enrollment.

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

**RESULT** A payment plan Support Task was submitted per their request. The beneficiary agreed to pay <<**AMOUNT**>> in addition to their monthly premium. The beneficiary current payment election is direct billing via invoice. Their first payment with this payment plan will be due upon receipt of their next invoice.

[Top of the Document](#TopOfDoc)

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| EFT or RCD Stopped without Request (BILLING) |

FILL IN THE BENEFICIARY-SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that their <<**ELECTRONIC FUNDS TRANSFER EFT DEDUCTIONS**>> <<**REOCCURRING CREDIT DEBIT CARD DEDUCTIONS RCD**>> were stopped without their request.

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

**Result (select option below):**

* The beneficiary did not wish to re enroll in automatic payments for their premium.
* The beneficiary was re enrolled in <EFT or RCD> per their request.
*  The beneficiary wished to re-enroll in automatic payments via self-service options. The beneficiary was educated on the self-service options for setting up automatic payments.

[Top of the Document](#TopOfDoc)

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| Multiple Attempts to Set Up EFT (BILLING) |

**REASON** The beneficiary is dissatisfied that their premium payment election is yet to be set up for Electronic Funds Transfer EFT.

**ACTION** The beneficiary was informed that EFT can take up to two billing cycles for this automatic payment option to take effect. The beneficiary 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 beneficiary must complete all the required information including their signature and a voided check with the request. The beneficiary can also request EFT by calling Customer Care.

* **If previous requests received:**

The Plan confirmed that their previous request(s) received were incomplete.

* **If no previous requests received:**

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

**RESULT** The Plan processed an EFT request for the beneficiary.

[Top of the Document](#TopOfDoc)

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| Multiple Attempts to Set Up RCD (BILLING) |

**REASON** The beneficiary is dissatisfied that their premium payment election is yet to be set up for reoccurring credit or debit card deductions RCD.

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

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

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

[Top of the Document](#TopOfDoc)

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

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that their premium payment election is yet to be set up for <<**SOCIAL SECURITY ADMINISTRATION SSA DEDUCTIONS**>><<**RAILROAD RETIREMENT BOARD RRB DEDUCTIONS**>>.

**ACTION** The beneficiary was informed that SSA RRB deductions can take up to two billing cycles for this automatic payment option to take effect. Beneficiaries enrolled in an Employer Group Waiver Plan (EGWP), Low Income Subsidy with No premium due, and beneficiaries with a temporary Medicare number are ineligible for SSA RRB deductions.

The Plan has confirmed this is the beneficiary s initial valid request for SSA RRB deductions.

**RESULT** The Plans submitted the beneficiary s request for <<**SSA**>> <<**RRB**>> deductions. If the SSA RRB request is approved the Social Security Administration will send a confirmation letter that will also indicate when the SSA RRB is scheduled to start.

[Top of the Document](#TopOfDoc)

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| Issue Paying Premium at the Pharmacy (BILLING) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that they are having issues paying their premium at the pharmacy.

**ACTION** The beneficiary can pay their monthly premiums at any retail CVS Pharmacy excluding CVS pharmacies in Target. The pharmacy will scan the barcode on the invoice and allow the beneficiary to pay using cash, credit card or a debit card. Please note, the retail pharmacy cannot accept checks.

The Plan contacted the pharmacy and spoke with a pharmacy representative regarding the beneficiary s concerns.

**If payment made at the time of the call:**

At the time of the call, the beneficiary made a premium payment of <<**AMOUNT**>>.

**RESULT** The Plan relayed the information from the pharmacy representative to the beneficiary and apologized for any inconvenience or frustration the beneficiary experienced. The beneficiary was additionally provided with alternate payment methods for their monthly premium.

[Top of the Document](#TopOfDoc)

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| Issue Paying Premium through the IVR (BILLING) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** My Premium payments, balances, refund, statement requests, etc. is one of the many self service options the IVR offers. The beneficiary was educated that to pay their monthly premium they can call the number on the back of their card. The IVR system will then ask How may I help you? at this time the beneficiary can simply state pay premium. They will then be prompted to provide their date of birth and member ID.

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

**If payment made at the time of the call:** At the time of the call, the beneficiary made a premium payment of <<**AMOUNT**>>.

**RESULT** Enhancements are continuously made to the IVR system in an effort to improve the beneficiaries experience and to increase available self service options. The beneficiary was additionally provided with alternate payment methods for their monthly premium.

[Top of the Document](#TopOfDoc)

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| Issue Paying Premium via Payment Portal (BILLING) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that they are having issues paying their premium via the payment portal.

**ACTION** The Plan offers the opportunity to pay premiums online at [aetnamedicare.com](https://www.aetna.com/medicare.html?redirect=akamai&). The beneficiary was educated that to pay the premium online, they must click on the For Members tab and then click Payments in the column to the left. They should follow the prompts after clicking Pay Your Premium. The beneficiary will need their nine digit Payment ID number and a valid credit card or bank account information in order to complete the premium payment. If the member ID or invoice displays a longer ID number, the beneficiary should only enter the first nine digits. For newly enrolled beneficiaries, there can be up to a week delay before the beneficiary can make a payment via the portal.

**If payment made at the time of the call:** At the time of the call, the beneficiary made a premium payment of <<**AMOUNT**>>.

**RESULT** The Plan confirmed that there are currently no issues with the payment portal. The beneficiary was provided with alternate payment methods for their monthly premium. The Plan apologized for any dissatisfaction this may have caused.

[Top of the Document](#TopOfDoc)

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| CMS ISSUES |

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

[Top of the Document](#TopOfDoc)

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

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

**ACTION** Medicare regulations state that beneficiaries 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 beneficiary may use a coupon or discount card for a prescription drug if they do not use their insurance and pay out of pocket. The beneficiary 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 TrOOP accumulation.

**RESULT** As an alternative to a discount program, the beneficiary is encouraged to use a preferred pharmacy to lower their cost or speak to their provider about a lower cost alternative.

[Top of the Document](#TopOfDoc)

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

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

**ACTION** The Plan sent the beneficiary a Formulary list of covered drugs, Pharmacy Directory, and the Evidence of Coverage EOC booklet before October 15th. An LIS Rider was also provided informing the beneficiary they will pay the LIS copays instead of the plan copays.

**RESULT** The Plan educated the beneficiary that the LIS copays are established by the Centers for Medicare and Medicaid Services CMS and not the Plan. The LIS copays change annually. The beneficiary is able to appeal the level of subsidy with CMS.

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

[Top of the Document](#TopOfDoc)

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| Dissatisfaction with Mail Service Consent Process (CMS ISSUES) |

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

**ACTION** The Centers for Medicare and Medicaid Services CMS established a guidance that mail service pharmacies must obtain and document Expressed Ship Consent from beneficiaries on all newly received prescriptions prior to shipping them. This includes orders initiated by the CVS Caremark Automatic Refill Program ARP service, prescriber faxes, prescriber phone, and electronically submitted prescriptions. Expressed Ship Consent is not required when the beneficiary 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 beneficiary receives only those medications they actually need.

CVS Caremark Mail Service Pharmacys policy is to ship prescription orders without the beneficiarys consent based upon certain criteria. Under the modification, the beneficiary is only required to provide Expressed Ship Consent for their first order filled at the mail service pharmacy. If the beneficiary 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.

**RESULT** The Plan apologized for any inconvenience caused by the consent process. This policy assures only medication needed by the beneficiary is sent and charged to them. To avoid the consent process, the beneficiary 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.

[Top of the Document](#TopOfDoc)

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| CD/RD |

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[Top of the Document](#TopOfDoc)

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| Not Notified of Expiring Coverage Determination (CD/RD) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that they were not notified that the coverage determination CD for <<**MEDICATION**>>was expiring.

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

**RESULT** Plan 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. The beneficiary 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 beneficiary was advised that a CD renewal can be submitted 90 days prior to the expiration.

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

Beneficiary was transferred to the Clinical Team to <<**DISCUSS FORMULARY ALTERNATIVES**>> **or** <<**SUBMIT AN EXCEPTION**>>.

[Top of the Document](#TopOfDoc)

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| Physician Wrote Prescription So Additional Approval Should Not Be Necessary (CD/RD) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that although prescribed by the physician, a coverage determination CD is required for coverage of <<**MEDICATION**>>.

**ACTION** The Plan sent the beneficiary a Formulary list of covered drugs and Evidence of Coverage EOC booklet before October 15th. The Formulary informs the beneficiary 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 medications while keeping plan costs controlled for beneficiaries. All considerations were made based on the Food and Drug Administration FDA approved recommendations, clinical studies, and manufacturer guidelines.

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

In general, the Plans rules encourage beneficiaries 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 beneficiary and their provider to use that lower cost option. The Plan must also comply with Medicares 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 only beneficiaries in certain situations can get a temporary supply. This will give the beneficiary 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 call is transferred to Clinical Team include:**

Beneficiary was transferred to the Clinical Team to <<**DISCUSS FORMULARY ALTERNATIVES**>> **or** <<**SUBMIT AN EXCEPTION**>>.

[Top of the Document](#TopOfDoc)

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| Having to File Coverage Determination Annually (CD/RD) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that a coverage determination CD has to be filed annually.

**ACTION** The Plan sent the beneficiary a Formulary. The Formulary informs the beneficiary of which drugs are covered and their tier levels.

**RESULT** Records show a CDfor <<**MEDICATION**>>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 beneficiarys physician for the medication. Other times, the medication may no longer require a coverage determination for that year and the beneficiary will continue to receive the drug with no further action necessary.

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

**If CD is still required include:**

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

* Possibly get a temporary supply of the drug only beneficiaries in certain situations can get a temporary supply. This will give the beneficiary 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 call is transferred to Clinical Team include:**

Beneficiary was transferred to the Clinical Team to <<**DISCUSS FORMULARY ALTERNATIVES**>> **or** <<**SUBMIT AN EXCEPTION**>>.

[Top of the Document](#TopOfDoc)

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| CUSTOMER SERVICE |

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[Top of the Document](#TopOfDoc)

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

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

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

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

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

[Top of the Document](#TopOfDoc)

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

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

**ACTION** The beneficiary was educated that the Plans Adherence to Drug Therapy ADT program is a disease management program designed to improve beneficiarys adherence with their medication therapy. CVS Caremark offers the ADT program at no cost to the beneficiary. The program is voluntary, and beneficiaries 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 beneficiary wishes to opt out**

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

* **If the beneficiary does not request to opt out**

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

[Top of the Document](#TopOfDoc)

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

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

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

**RESULT** The beneficiary 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.

[Top of the Document](#TopOfDoc)

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

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

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

**RESULT** The beneficiary 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 beneficiary may have to spend on the phone. CCRs are instructed to ask the beneficiary if they would like to hold or would prefer that the CCR check back with the beneficiary every few minutes to inform them their issue is still being looked into.

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

[Top of the Document](#TopOfDoc)

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| Call Disconnected (CUSTOMER SERVICE) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** A review of the beneficiarys 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 beneficiary with their inquiry.

[Top of the Document](#TopOfDoc)

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| Multiple Transfers During Call (CUSTOMER SERVICE) |

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

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

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

The beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Authentication Process (CUSTOMER SERVICE) |

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

**ACTION** The Plan is required by the Health Insurance Portability and Accountability Act HIPAA of 1996, to protect the beneficiarys Personal Health Information PHI. 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 ID Number, Medicare Beneficiary Identifier MBI 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 beneficiarys first and last name First and last name can be used as an identifier for inbound calls only. Beneficiarys date of birth, full street address, employer or plan sponsor, zip code.

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

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

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

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

[Top of the Document](#TopOfDoc)

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| Offshore Customer Care Sites (CUSTOMER SERVICE) |

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

**ACTION** The Plan confirmed that the CCR located offshore was able to provide the information and or assistance requested by the beneficiary. However the call was transferred to a call center within the United States.

**RESULT** The Plan educated the beneficiary that there are multiple locations that calls may be routed, both within and outside the United States. Call centers housed in different locations ensure calls are answered timely 24 hours a day. The Plan ensured the beneficiary that all CCRs are provided with the same comprehensive training and are able to assist with all issues or concerns regardless of call center location. The Plan apologized for any dissatisfaction this may have caused.

[Top of the Document](#TopOfDoc)

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| Receives Too Many Phone Calls for Orders (CUSTOMER SERVICE) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that they are receiving too many phone calls for prescription orders.

**ACTION** The beneficiary has the option to update theirmessaging preferences to email and or text alert instead of a phone call.

**RESULT** The Plan apologized to the beneficiary for any dissatisfaction this may have caused. Although the beneficiary may opt to update theirmessaging preferences, the Plan advised that theymay still receive phone calls from the plan, as certain types of calls are made regardless of messaging preference. One example of the types of calls are high copay calls . These types of calls are made to a beneficiary when their order exceeds a certain amount based on their plan design. The Plan will attempt to contact them in an effort to obtain approval to ship the order in question and charge their payment method on file. Regrettably, the Plan cannot stop these calls from being made to the beneficiary.

**If messaging preference was updated include:**

Per the beneficiarys request, their messaging preferences were updated to <<**METHOD**>>.

[Top of the Document](#TopOfDoc)

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| Received Correct Medication but Different Size or Color (CUSTOMER SERVICE) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that <<**MEDICATION**>>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 medication and strength, the appearance size, shape, color of the medication may differ from manufacturer to manufacturer.

**RESULT** The beneficiary or prescriber may request that a generic from a specific manufacturer be dispensed, as the pharmacy may carry medications 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 beneficiarys needs. If a specific manufacturer is not covered under the Plan, a beneficiary may choose to pay out of pocket or a suitable alternative can be requested from the prescriber.

[Top of the Document](#TopOfDoc)

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| Unable to Cancel Order (CUSTOMER SERVICE) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that **they were** unable to cancel their prescription order in process.

**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 beneficiary initiated order include:**

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

**If requesting to return non-beneficiary initiated order include:**

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

[Top of the Document](#TopOfDoc)

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| ENROLL/DISENROLL |

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[Top of the Document](#TopOfDoc)

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

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

**ACTION** The Plan educated the beneficiary that the Centers for Medicare and Medicaid Services CMS will initiate a facilitated enrollment into a Prescription Drug Plan PDP for Medicare beneficiaries who are eligible for Low Income Subsidy LIS also known as Extra Help but not eligible for full Medicaid benefits. If the beneficiary 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 beneficiary has prescription drug coverage.

**RESULT** The Plan educated the beneficiary 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 beneficiaries 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 beneficiary 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 or 1 800 633 4227, or enrolling into another Medicare PDP.

[Top of the Document](#TopOfDoc)

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

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

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

**RESULT** The Plan educated the beneficiary 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 beneficiaries 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 beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Dissatisfied with Disenrollment Process (ENROLL/DISENROLL) |

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

**ACTION** The Plan educated the beneficiary that CMS allows them to enroll, switch, or disenroll from a PDP during the Annual Election Period AEP 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 beneficiary 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 beneficiary for the first of the following month and send them confirmation of disenrollment letter or inform them their disenrollment request was denied.

[Top of the Document](#TopOfDoc)

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

**REASON** The beneficiary 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 PDP. 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 CMS 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 beneficiary to determine a correct permanent address. The Plan fulfills this requirement by sending the beneficiary an Out of Area OOA letter that has a RVF enclosed to complete and return to the Plan.

The beneficiary 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 beneficiary contact us to verify the address to prevent them from being disenrolled due to being OOA.

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

**RESULT**

* **If removed from OOA process:**

The beneficiarys 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 beneficiarys 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 beneficiarys address as requested and they were transferred to the enrollment team to submit a new enrollment.

[Top of the Document](#TopOfDoc)

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| Multiple Attempts to Disenroll (ENROLL/DISENROLL) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** The Plan educated the beneficiary that CMS allows them to enroll, switch, or disenroll from a PDP during the Annual Election Period AEP 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.

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 beneficiary for the first of the following month and send them confirmation of disenrollment letter or inform them their disenrollment request was denied.

**RESULT** The Plan has confirmed that this is not the beneficiarys initial request to disenroll. However, the beneficiarys previous disenrollment request was denied due to <<**the request not being completed**>> <<**not having a valid SEP out of the AEP**>>. The beneficiary was informed that they can disenroll during the AEP or submit a valid completed disenrollment request with a SEP.

[Top of the Document](#TopOfDoc)

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

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** The Initial Enrollment Period IEP 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 beneficiarys enrollment was during the beneficiarys IEP.

**RESULT** CMS provides specific enrollment effective dates for when a beneficiary enrolls during their 7 month IEP and cannot be modified. Plan apologized and confirmed the effective date is valid.

[Top of the Document](#TopOfDoc)

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| Received RVF but did not Move (ENROLL/DISENROLL) |

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

**ACTION** The beneficiary 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 CMS via Transaction Response Code TRC 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 beneficiaryto determine their correct permanent address. The Plan fulfills this requirement by sending the beneficiary an Out of Area OOA letter that has a Residence Verification Form RVF.

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

**RESULT** The beneficiary confirmed that they had not moved and their address remains the same. A request was submitted confirming the beneficiarys address in order to remove them from the OOA process.

[Top of the Document](#TopOfDoc)

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| Incorrect Address on File (ENROLL/DISENROLL) |

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

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

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

* **SSI beneficiary - updated address still in service area:**

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

* **SSI beneficiary - updated address NOT in service area:**

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

[Top of the Document](#TopOfDoc)

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| Too Much Mail (ENROLL/DISENROLL) |

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

**ACTION** The Plan informed the beneficiary that Medicare requires the plan to send certain documents such as an Annual Notice of Change ANOC, Explanation of Benefits EOB, and other letters with important plan information.

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

* **If Plan allows for electronic EOBs**

The beneficiary can opt in to receive electronic EOBs online at [www.caremark.com](http://www.caremark.com/) 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 beneficiary. The Plan advised that regrettably, the Centers for Medicare and Medicaid Services CMS mandate that all Medicare Part D PDPs send these types of documents to all enrolled beneficiaries.

[Top of the Document](#TopOfDoc)

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

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

**ACTION** All Medicare Part D Prescription Drug Plans PDPs are required by the Centers for Medicare and Medicaid Services CMS to mail their beneficiaries a monthly report, known as an EOB, if they have purchased any covered medications 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 medication claims, the beneficiarys current prescription drug plan coverage stage, their progression towards the next coverage stage, and any important formulary changes to medications covered by the Plan.

**RESULT For Plans offering electronic EOBs:**

The Plan recommended that the beneficiary sign up for electronic EOBs. With electronic EOBs, a paper document is not mailed. Beneficiary has the option to print the EOB as needed.

The Plan apologized for the beneficiarys dissatisfaction.

[Top of the Document](#TopOfDoc)

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

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

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

The Plan educated the beneficiary that the Centers for Medicare & Medicaid Services CMS allows enrollment into a plan during specific time periods. The IEP lasts for 7 months, 3 months prior to and 3 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 medication are not qualifying SEPs.

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

[Top of the Document](#TopOfDoc)

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| MARKETING |

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

[Top of the Document](#TopOfDoc)

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| Plan Materials Confusing (MARKETING) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied with plan materials being confusing.

**ACTION** The beneficiary was informed that the Centers for Medicare and Medicaid Services CMS requires the Plan to mail specific plan materials.

The Plan reviewed <<**DOCUMENT TYPE**>> with the beneficiary and apologize for the confusion this may have caused.

**RESULT** The Plan further advised the beneficiary that they can always contact Customer Care to help answer any of their questions regarding any document they receive.

[Top of the Document](#TopOfDoc)

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| Charged Different Price than Displayed on Plan Website (MARKETING) |

**REASON** The beneficiary is dissatisfied that they were charged a different price than what was displayed on the Plans website.

**ACTION** The Plans website provides coverage, cost, and benefit information for their beneficiaries. For more accurate information, the beneficiary should access www.caremark.com and Sign In to their personal profile.

The beneficiary was educated that the drug costs displayed are estimates and may vary based on the specific quantity, strength, and or dosage of the medication, the order in which the beneficiary purchases the prescriptions and the pharmacy used.

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

[Top of the Document](#TopOfDoc)

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| Charged Different Price than Displayed on caremark.com (MARKETING) |

**REASON** The beneficiary is dissatisfied that they were charged a different price than what was displayed on caremark.com.

**ACTION** Plan confirmed the beneficiary paid the correct cost sharing for their medications. Caremark.com provides coverage, cost, and benefit information for their beneficiaries.

The beneficiary was educated that the drug costs displayed are estimates and may vary based on the specific quantity, strength, and or dosage of the medication, the order in which the beneficiary purchases their prescriptions and the pharmacy used.

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

[Top of the Document](#TopOfDoc)

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| Dissatisfied with Telemarketing Calls (MARKETING) |

**REASON** The beneficiary is dissatisfied that they continue receiving telemarketing calls from the Plan.

**ACTION** The beneficiary was informed that the Plan does not provide advertisements through the Interactive Voice Response IVR system. The beneficiary was provided the correct phone number to call for customer service.

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

[Top of the Document](#TopOfDoc)

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| Price Difference Between Medicare Plan Finder and Estimated Cost/Out of Pocket Cost/Plan Website (MARKETING) |

**REASON** The beneficiary expressed dissatisfaction with the price difference between Medicare Plan Finder and their Plans website.

**ACTION** Beneficiaries may use the Medicare Plan Finder Website or contact 1 800 Medicare for assistance in choosing a Medicare Part D plan. The information on the Medicare website may be confusing to beneficiaries when comparing the information to the Plans website or Plan marketing materials. Beneficiary was educated that the Plans website is updated regularly with cost information.

**RESULT** The Plan takes the necessary measures to ensure that all information is correct between Medicare.gov and the Plans website. The Plan conducts a biweekly check that compares the costs of medications between the websites to ensure accurate information. Please note the drug costs displayed are estimates and may vary based on the specific quantity, strength, and or dosage of the medication, the order in which the beneficiary purchases the prescriptions and the pharmacy used. The Plan apologized for any dissatisfaction this may have caused. Beneficiary was encouraged to contact Customer Care to confirm all medication cost sharing.

[Top of the Document](#TopOfDoc)

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| MEMBER MATERIALS |

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

[Top of the Document](#TopOfDoc)

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| Disenrolled but Still Receiving an Invoice (MEMBER MATERIALS) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

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

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

[Top of the Document](#TopOfDoc)

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| Not Receiving Premium Invoice (MEMBER MATERIALS) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** The Plan confirmed that the beneficiarys 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 beneficiarys 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 LEP is applied to ensure the LEP amount is accurately billed. If the beneficiary has a $0.00 balance at the time of invoicing, a premium invoice will not be sent.

The Plan advised the beneficiary 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 beneficiarys current premium balance is <<**AMOUNT**>>. Premium invoices are being generated and mailed the address on file. Beneficiary confirmed the address is correct. If the beneficiary is not receiving premium invoices, then they will need to contact the local United States Postal Service USPS office to ensure mail is being received and delivered.

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

[Top of the Document](#TopOfDoc)

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| Did Not Receive ID Card (MEMBER MATERIALS) |

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

**ACTION** The Plan confirmed that the beneficiary was mailed Plan materials including a membership Identification ID card to the address on file.

**Include if address was incorrect:** The beneficiary indicated their address was changed. Therefore, the Plan updated their address per the beneficiarys request.

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 beneficiary with the pharmacy processing information until they receive their new ID card.

The Plan informed the beneficiary 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 beneficiary 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 beneficiary and educated the beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Unable to Read Prescription Labels (MEMBER MATERIALS) |

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

**ACTION** The beneficiary 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 informed the beneficiary 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.

**Include if the beneficiary requests a ScripTalk Station be mailed to them:**

Per the beneficiarys request for a ScripTalk Station, the Plan can fill out the form online at [www.envisionamerica.com](https://www.envisionamerica.com/).

[Top of the Document](#TopOfDoc)

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| Upset with Packaging/Bottle Caps (MEMBER MATERIALS) |

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

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

**RESULT** 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 beneficiary received their medication 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 simply twist on and twist off. Snap off caps are not available. The Plan educated the beneficiary to save and reuse these caps for future orders.

**If requested include:** The Plan requested caps to be mailed to the beneficiary.

[Top of the Document](#TopOfDoc)

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| Bottle Size Too Big or Too Small (MEMBER MATERIALS) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction with the size of the prescription bottles as they are too <<**BIG/SMALL**>>.

**ACTION** The beneficiary 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 remain as cost efficient as possible. The Plan apologized for any dissatisfaction this may have caused.

[Top of the Document](#TopOfDoc)

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| Refill Date Missing from Label (MEMBER MATERIALS) |

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

**ACTION** The beneficiary was advised that the CVS Caremark Mail Service Pharmacy labels do not provide the refill next order date. This decision was made to prevent inaccuracies due to unforeseen changes in time sensitive prescription medications, prescription quantity, or simply 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.

[Top of the Document](#_top)

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| Not Receiving Plan Materials in their Preferred Language (English/Spanish) (MEMBER MATERIALS) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that they are not receiving plan materials in their preferred language, <<**LANGUAGE**>>.

**ACTION** The beneficiary was informed that they may receive plan materials in their non preferred language if the plan materials were processed and or mailed prior to updating their preferred language.

The Plan has confirmed that the beneficiarys language preference is set to their preferred language.

**OR** if the language preference is set not set to their preferred language

A request was submitted to update the beneficiarys language to their preferred language.

As the beneficiary indicated that they did not receive their plan materials in their preferred language, the Plan submitted a request to mail a copy of the requested plan materials to their address on file.

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

[Top of the Document](#TopOfDoc)

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| PLAN BENEFIT |

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

[Top of the Document](#TopOfDoc)

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| Upset with Premium Increase (PLAN BENEFIT) |

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

**ACTION** The Plan sent the beneficiary an Annual Notice of Changes, ANOC, to the address on file. The ANOC provided the beneficiary with Plan benefit information for the Plan year, which included the premium amount. Per Medicare guidance, the ANOC is sent to plan beneficiaries before September 30th each year to provide sufficient time to review any changes and decide whether the plan will continue to meet their needs in the next year. Medicare allows beneficiaries to make enrollment changes during the Medicare Annual Election Period AEP, which occurs October 15 through December 7.

**RESULT** The Plan confirmed the beneficiarys premium for the current Plan year has increased. The Plan apologized and advised the beneficiary 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 beneficiary that the Plan continually looks for innovative solutions to make prescription drug coverage more affordable to our beneficiaries.

The Plan understands that the premium increase can cause beneficiaries financial hardship. Therefore, the Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.ssa.gov).

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

[Top of the Document](#TopOfDoc)

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| No Savings through Mail Service Pharmacy (PLAN BENEFIT) |

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

**ACTION** The beneficiary 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 beneficiary with the convenience of having their prescription drugs delivered to their door at no extra cost. The beneficiary can also place orders for 90 day supplies of common maintenance medications 24 hours a day, 7 days a week.

**RESULT** Although it may seem as though the mail service pharmacy is not assisting the beneficiary with lower copays compared to retail, they are still receiving benefits and discounts as a beneficiary of the Plan.

Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.ssa.gov).

Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state if applicable. Furthermore, the beneficiary can utilize their State Health Insurance and Assistance Program SHIP, which is a free program that offers one on one counseling and assistance to people with Medicare and their families.

[Top of the Document](#TopOfDoc)

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| LIS Cost Increase Due to Level Change (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

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

**RESULT** The Plan has confirmed the beneficiarys claims have adjudicated correctly based on their current LIS Level. The beneficiary was advised that they may contact Social Security at 18007721213 in regards to reevaluating their LIS level.

[Top of the Document](#TopOfDoc)

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| LIS Cost Increase Due to New Year and Previously in Catastrophic Stage (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** Plan records show the beneficiary is eligible for LIS Level <<**NUMBER**>>.

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

**RESULT** The beneficiary is no longer in the Catastrophic Coverage Stage as it is now a new year. During the Initial stage they are responsible for the LIS standard copays coinsurance or the Plans non LIS cost, whichever is less. Once the amount the beneficiary and Medicare pay as the Extra Help reaches $8,000 in the 2024 Plan year, the beneficiary will be responsible for a $0.00 copay for all covered drugs for the remainder of the plan year.

As of <<**DATE**>>, the beneficiary has <<**AMOUNT**>> remaining to reach the Catastrophic Coverage Stage.

The Plan has confirmed the beneficiarys claims have adjudicated correctly based on their current LIS Level. The beneficiary was advised that they may contact Social Security at 1 800 772 1213 in regards to reevaluating their LIS level.

[Top of the Document](#TopOfDoc)

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| Coverage Gap Dissatisfaction (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**Note:** If the member is enrolled in an enhanced plan that provides continued coverage for lower tiers during the Coverage Gap, 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 in question is on the [Tier Exception exclusion list (010234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=90c3c22e-86f7-46a9-934a-d5b17c67227d).

**REASON** The beneficiary expressed dissatisfaction with the cost of their medications during the coverage gap.

**ACTION** The Plan sent the beneficiary a Formulary list of covered drugs, Pharmacy Directory and Evidence of Coverage EOC booklet before October 15th.

The beneficiary was advised to refer to What You Will Pay for Your Part D Prescription Drugs, of their EOC. The EOC provided information regarding the Plans different coverage stages per Medicare regulation.

Medicare Part D plans have four stages of coverage also known as payment stages. The amount the beneficiary pays for a drug depends on which of these stages they are in at the time a prescription is filled, the tier level of the drug and the pharmacy used to fill the prescription. Stage one is the yearly deductible stage, stage two is the initial coverage stage, stage three is the coverage gap stage and stage four is the catastrophic coverage stage.

Once the beneficiary accumulates a total drug spend as indicated in the EOC, the beneficiary will move to the coverage gap stage. The beneficiary will remain in this stage until their year to date true out of pocket TrOOP costs reach $8,000 in 2024. During this stage, the beneficiary is responsible for 25% of the price for all drugs.

During the catastrophic coverage stage, the beneficiary will have a $0.00 copay.

**RESULT** Plan advised that the coverage gap is not just particular to their plan, but is a part of every Medicare prescription drug plan.

Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at www.ssa.gov.

Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state if applicable. Furthermore, the beneficiary can utilize their State Health Insurance and Assistance Program SHIP, which is a free program that offers one on one counseling and assistance to people with Medicare and their families.

[Top of the Document](#TopOfDoc)

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| Overall Plan Design Dissatisfaction (PLAN BENEFIT) |

**REASON** The beneficiary expressed dissatisfaction with the plan design changes from year to year.

**ACTION** Plan confirms an Annual Notice of Changes ANOC was mailed to the beneficiary which included a Summary of Important Costs. This table compared the current years benefits with the upcoming years benefits in several important areas including the plan premium and copays coinsurance for each drug tier level.

All beneficiaries are encouraged to read the information in their ANOC so they can make an informed decision regarding their prescription coverage for the next calendar year.

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

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

Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.ssa.gov/prescriptionhelp).

Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state if applicable. Furthermore, the beneficiary can utilize their State Health Insurance and Assistance Program SHIP, which is a free program that offers one on one counseling and assistance to people with Medicare and their families.

[Top of the Document](#TopOfDoc)

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| Tier Change Dissatisfaction (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary 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 mailed the Annual Notice of Changes ANOC documents to the beneficiarys address on file. Per Medicare guidance, the ANOC is sent to plan beneficiaries before September 30th each year to provide 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 medication on a higher tier because lower cost generics or alternatives are available on a lower tier.

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

Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.ssa.gov/prescriptionhelp).

Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state if applicable. SPAP contact information is <<**NONE**>> or <<**NAME**>> and <<**PHONE NUMBER**>>.

[Top of the Document](#TopOfDoc)

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| Unhappy with Transition Fill Process (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction with the transition fill TF process.

**ACTION** The Plan sent the beneficiary a Formulary list of covered drugs and Evidence of Coverage EOC booklet before October 15th. The Formulary is a list of covered drugs selected by the Plan in consultation with a team of healthcare providers.

**RESULT** A review of the formulary confirms a Coverage Determinationis required for coverage of <<**MEDICATION**>>. The Plan has confirmed a 30 day supply of the drug was filled under a transition fill TF. Further fills of the drug cannot be satisfied without an approved coverage determination.

The beneficiary was informed that a TF provides beneficiaries with appropriate therapy and prevents gaps in drug coverage while educating beneficiaries, prescribers, and pharmacy providers on formulary options. Transition fills are provided during the first 90 days from the beneficiarys eligibility effective date or the first 90 days after the beneficiary experiences a plan change. Beneficiaries and prescribers are then sent a written notice via U.S. Mail, within three business days of receiving a TF, to notify the beneficiary that a transition supply was provided and the beneficiary 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 beneficiarys address.

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

Beneficiary was transferred to the Clinical Team to <<**DISCUSS FORMULARY ALTERNATIVES**>> **or** <<**SUBMIT AN EXCEPTION**>>.

[Top of the Document](#TopOfDoc)

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| Plan not Paying towards Medication (PLAN BENEFIT) |

**REASON** The beneficiary expressed dissatisfaction regarding the Plan not paying towards the cost of their medications.

**ACTION** The Plan sent the beneficiary an Evidence of Coverage EOC booklet before October 15th.

**RESULT** The Plan advised the beneficiary to review What You Will Pay for Your Part D Prescription drugs, of their EOC. If the covered drug costs less than the copay coinsurance amount, the beneficiary will pay the lower price for the drug. The Plan will only pay on a medication when the allowed cost is over the beneficiarys standard copay coinsurance.

Although it may seem as though the Plan is not assisting the beneficiary with their medication costs, the beneficiary is still receiving benefits and discounts as a beneficiary of the Plan. Plan educated beneficiary 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.

Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.ssa.gov/prescriptionhelp).

Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state if applicable. Furthermore, the beneficiary can utilize their State Health Insurance and Assistance Program SHIP, which is a free program that offers one on one counseling and assistance to people with Medicare and their families.

[Top of the Document](#TopOfDoc)

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| Recoupment Process Dissatisfaction (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

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

Plan confirms a recoupment invoice statement, dated <<**DATE**>> was mailed in the amount of <<**AMOUNT**>>.

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

**RESULT** 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 beneficiarys 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 beneficiarys credit. This will not affect the beneficiarys enrollment with the Plan.

[Top of the Document](#TopOfDoc)

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| Dissatisfaction with Cost after Approved Formulary Exception (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** Plan confirms the beneficiary received an approved formulary exception for <<**NAME OF MEDICATION**>>.

**RESULT** The Plan advised the beneficiary to review What is an Exception? of their EOC.

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

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

Plan also provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.ssa.gov/prescriptionhelp).

Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state if applicable. Furthermore, the beneficiary can utilize their State Health Insurance and Assistance Program SHIP, which is a free program that offers one on one counseling and assistance to people with Medicare and their families.

[Top of the Document](#TopOfDoc)

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| Dissatisfaction with Cost Due to Deductible (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**Note:** If the member is enrolled in an enhanced plan that provides continued coverage for lower tiers during the Coverage Gap, 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 in question is on the [Tier Exception exclusion list (010234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=90c3c22e-86f7-46a9-934a-d5b17c67227d).

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

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

**RESULT** The beneficiary 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.

The Deductible Stage is the first payment stage of drug coverage. This stage begins when the beneficiary 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 beneficiary has paid the deductible, they leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

The Plan advised the beneficiary that they can submit a Tiering Exception for their medication, but it is not guaranteed to be approved or that it will apply during the Deductible Stage.

Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.ssa.gov).

Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state if applicable. Furthermore, the beneficiary can utilize their State Health Insurance and Assistance Program SHIP, which is a free program that offers one on one counseling and assistance to people with Medicare and their families.

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

[Top of the Document](#TopOfDoc)

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| Dissatisfaction with Plan’s Override Policy (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction due to the plans override policy regarding<<**INSERT TYPE OF OVERRIDE**>>e.g., vacation, lost stolen, etc.

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

**RESULT**

**Use one of the following:**

1. Per the Plan design <<**TYPE OF PBO**>>is allowed <<**SPECIFY RESTRICTIONS**>>.

There are certain circumstances where the beneficiary may receive a Plan Benefit Override PBO to obtain their medication 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 <<**NAME OF MEDICATION**>>.

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 beneficiary is in dire need of the medication, they are allowed to pay out of pocket or request samples if available from their prescriber.

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

[Top of the Document](#TopOfDoc)

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| Medication Not Covered Under Med D Law (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction with their medication <<**NAME OF MEDICATION**>>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
* Nonprescription drugs over the counter drugs

**RESULT** 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 medications 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, as long as they are approved by the United States Food and Drug Administration FDA for such treatment. In these circumstances the beneficiary can request a formulary exception for coverage of the drug. The beneficiary can request this Formulary Exception themselves through Customer Care or their prescriber may request it.

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

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

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

Beneficiary was advised to speak to their prescriber regarding an alternative medication that is covered under Medicare Part D law.

[Top of the Document](#TopOfDoc)

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| Dissatisfaction with Utilization Rate (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

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

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

* Mail Service Pharmacy When <<**PERCENTAGE**>>% of the day supply has been utilized. This provides the beneficiary 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 beneficiarys door.

Retail Pharmacy When <<**PERCENTAGE**>>%of 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 medications are filled only when necessary.

**RESULT** The Plan advised the beneficiary of our commitment to help beneficiaries get the most benefit from their prescriptions and to understand how their coverage works. If the beneficiary is out of medication due to a specific circumstance, an override may allow them to receive the medication sooner than the refill date.

[Top of the Document](#TopOfDoc)

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| Dissatisfaction with Tier Exception Not Applicable during Coverage Gap (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction because their approved tier exception for <<**NAME OF MEDICATION**>>does not apply during the coverage gap stage of their plan benefit.

**ACTION** A tier exception was approved for the drug to pay at Tier at a lower tier.

**RESULT** The Plan confirms the beneficiary is currently in the coverage gap stage. The Plan advised the beneficiary that during the coverage gap stage tier levels do not apply. Tier levels are only applied during the initial coverage stage. During the gap, cost share is based on generic vs. brand name drug. A tier exception is only applicable if their plan has an enhanced benefit that provides coverage during the coverage gap for specific tier levels.

The Plan advised that after they accumulate $8,000 in true out of pocket TrOOP costs in 2024 they will enter the catastrophic stage where they will have a $0.00 copay.

Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.ssa.gov).

Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state if applicable. Furthermore, the beneficiary can utilize their State Health Insurance and Assistance Program SHIP, which is a free program that offers one on one counseling and assistance to people with Medicare and their families.

[Top of the Document](#TopOfDoc)

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| Medication Not Eligible for Tier Exception (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction because <<**NAME OF MEDICATION**>>is not eligible for a Tier Exception lower copay or coinsurance.

**ACTION** The Plan sent the beneficiary a Formulary list of covered drugs, Pharmacy Directory and the Evidence of Coverage EOC booklet before October 15th. The Formulary informs the beneficiary of which drugs are covered and their tier levels.

**RESULT** 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 beneficiary 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 beneficiary to speak to their prescriber regarding a lower cost alternative.

The Plan provided Extra Help information and encouraged the beneficiary 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 beneficiary can also apply for Extra Help online at [www.ssa.gov](http://www.socialsecurity.gov/prescriptionhelp).

The Plan advised the beneficiary of the State Pharmacy Assistance Program SPAP available in their state, if applicable. SPAP contact information is <<**NONE**>>or <<**NAME**>>and <<**PHONE NUMBER**>>.

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

[Top of the Document](#TopOfDoc)

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| Received Transition Fill and Not the Full Day Supply (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that <<**MEDICATION**>>was not filled for the full prescribed day supply.

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

**RESULT** A review of the formulary confirms a Coverage Determinationis required for coverage of the drug.

The Plan has confirmed a 30 day supply of the drug was filled under a transition fill TF. 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 beneficiary was informed that a TF provides beneficiaries with appropriate therapy and prevents gaps in drug coverage while educating beneficiaries, prescribers, and pharmacy providers on formulary options. Transition fills are provided during the first 90 days from the beneficiarys eligibility effective date or the first 90 days after the beneficiary experiences a plan change. The Plan allows multiple fills up to a 30 day supply. Beneficiaries and prescribers are then sent a written notice via U.S. Mail, within three business days of receiving a TF, to notify the beneficiary that a transition supply was provided and the beneficiary 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 beneficiarys address.

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

The Plan educated the beneficiary that they can request a Formulary Exception for this medication Beneficiary was transferred to the Clinical Team to <<**DISCUSS FORMULARY ALTERNATIVES**>> **or** <<**SUBMIT AN EXCEPTION**>>.

**If call is NOT transferred to Clinical Team include:**

The Plan confirmed an approved CD for this medication is on file.

[Top of the Document](#TopOfDoc)

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| Not Aware TrOOP Started at $0 at Beginning of Plan Year (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that true out of pocket TrOOP costs begin at 00.00 dollars each year.

**ACTION** The Plan sent the beneficiary an **ANNUAL NOTICE OF CHANGES ANOC** which included the Formulary list of covered drugs, Pharmacy Directory and Evidence of Coverage EOC booklet before October 15th.

**RESULT** Medicare Part D plans have four stages of coverage also known as payment stages. The amount the beneficiary pays for a drug depends on which of these stages he is in at the time a prescription is filled, the tier level of the drug and the pharmacy used to fill the prescription. Stage one is the yearly Deductible Stage, stage two is the Initial Coverage Stage, stage three is the Coverage Gap Stage and stage four is the Catastrophic Coverage Stage.

For the current Plan year, once the beneficiary accumulates $5,030in total yearly drug costs, they will move to the coverage gap stage and will remain in this stage until their year to-date true out-of-pocket TrOOP costs reach $8,000.If the TrOOP amount is met, the beneficiary will move on to the catastrophic coverage stage for the remainder of the Plan year.

The total drug cost and TrOOP amount to accumulate, prior to transitioning into a new stage, changes yearly. Therefore, accumulations begin at $0.00 each year. The beneficiary was advised that the Plan informs all beneficiaries annually of these changes in the EOC document.

[Top of the Document](#TopOfDoc)

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| Pharmacy Network Dissatisfaction (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

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

The Pharmacy Directory informs the beneficiary 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 beneficiary may go to either type of network pharmacy to receive their covered prescription drugs.

**RESULT** The Plan provided the beneficiary with three preferred pharmacies in their area.

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

The beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Pharmacy Not Preferred Pharmacy (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that <<**PHARMACY NAME**>> is not a preferred pharmacy this year.

**ACTION** The beneficiary 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 beneficiary with a list of preferred pharmacies near their residence.

[Top of the Document](#TopOfDoc)

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| Pre-payment for Mail Service Orders (PLAN BENEFIT) |

**REASON** The beneficiary 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 beneficiary was informed that the Plan offers the following convenient methods of payment for prescription orders Credit Debit card, Electronic check, or regular check when ordering through the mail.

If the beneficiary 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 beneficiary also has the option to obtain their prescription via retail.

**Include for $0 orders.**

Although the beneficiarys prescription order may be estimated as a $0.00 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 option)**

* The beneficiary declined adding a payment method on file or obtaining the prescription order.
* A request was submitted to have the prescription(s) transferred to the retail pharmacy per the beneficiarys request.
* The beneficiary added a payment method on file and the prescription order was successfully submitted.

[Top of the Document](#TopOfDoc)

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| Order Ineligible for Fill and Bill (PLAN BENEFIT) |

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

**Fill and Bill is client specific. Review the Client’s CIF to confirm the Client does not allow Fill and Bill.**

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

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.

**Result (choose option)**

* The beneficiary declined adding a payment method on file or obtaining the prescription order.
* A request was submitted to have the prescription(s) transferred to the retail pharmacy per the beneficiarys request.
* The beneficiary added a payment method on file and the prescription order was successfully submitted.

[Top of the Document](#TopOfDoc)

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| Prescription Not Eligible for the Automatic Refill Program (ARP) (Controlled Substance) (PLAN BENEFIT) |

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

**ACTION** The Automatic Refill Program ARP allows beneficiaries to receive prescription refills and renewals of maintenance drugs automatically. Beneficiaries 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 beneficiary was informed that the ARP is available for common maintenance medications, 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 renewal restrictions.

[Top of the Document](#TopOfDoc)

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

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** The Automatic Refill Program ARP allows beneficiaries to receive prescription refills and renewals of maintenance drugs automatically. Beneficiaries 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 beneficiary 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 has confirmed the prescription <<**HAS NO REMAINING REFILLS**>> **or** <<**IS EXPIRED**>>.A new prescription request was submitted via FastStart.

[Top of the Document](#TopOfDoc)

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| Prescription not Enrolled in Automatic Refill Program (ARP) - No Plan Error (PLAN BENEFIT) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction that theirprescription**(s)** <<**WAS/WERE**>>not enrolled in the Automatic Refill ARP as requested.

**ACTION** The Automatic Refill Program ARP allows beneficiaries to receive prescription refills and renewals of maintenance drugs automatically. Beneficiaries 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 medications 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.

**RESULT** The Plan has confirmed that this is the beneficiarys initial contact with the Plan requesting to enroll the prescription**(s)** in the ARP. To enroll prescriptions in ARP the beneficiary can either call Customer Care, submit an ARP form, or enroll the prescription on the Plans website at their convenience.

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

The following prescriptions were enrolled in ARP.

<<**LIST NAME OF MEDICATION(S)**>>

[Top of the Document](#TopOfDoc)

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| Professional Service (PPS) Codes (PLAN BENEFIT) |

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

**ACTION** The beneficiary was educated that the Plan conducts a drug utilization review DUR of their prescriptions claims to ensure that benefits are being administered according to the terms of coverage, as well as ensuring the beneficiarys health safety. Edits are implemented to improve control at Point of Sale POS 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 PPS is entered by a pharmacist to override the reject when applicable and to document their action for each reject.

The Plan confirmed that the beneficiarys 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 inconvenience. These alerts prompt the dispensing pharmacist to take action that will avoid potential safety concern. The pharmacist may consult with the prescriber, counsel the beneficiary, or choose not to fill the prescription to avoid a negative clinical outcome.

[Top of the Document](#TopOfDoc)

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| PRIVACY |

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

[Top of the Document](#TopOfDoc)

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| Concerned that Information is being Shared Without Consent (PRIVACY) |

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

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

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

[Top of the Document](#TopOfDoc)

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| Received Another Beneficiary's Mail; HIPAA Violation (PRIVACY) |

**REASON** The beneficiary is dissatisfied that they received another beneficiarys plan correspondence.

**ACTION** The Plan confirmed that plan materials that were addressed to someone other than the beneficiary were mailed to their address on file.

The Plan notified the Privacy Office of this matter. The Privacy Officer will conduct an individual investigation.

**RESULT** A copy of the correct plan materials were mailed to the correct beneficiarys address on file. The Plan apologized for any dissatisfaction this may have caused the beneficiary.

**Note:** DO NOT include PHI or PII that may violate another individuals HIPAA rights.

[Top of the Document](#TopOfDoc)

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| Received Another Beneficiary’s Rx Order; HIPAA Violation (PRIVACY) |

**REASON** The beneficiary is dissatisfied that they received another beneficiarys prescription order.

**ACTION** The Plan has confirmed an order that was addressed to someone other than the beneficiary was mailed to the beneficiarys address on file. The Plan has confirmed that a claim for the drug(s) dispensed was not processed on the beneficiarys account nor are there charges against their account.

The Plan notified the Privacy Office of this matter. The Privacy Officer will conduct an individual investigation.

**RESULT** A reship request was submitted to have the order mailed to the correct beneficiary. The Plan apologized for any dissatisfaction this may have caused the beneficiary.

**Note:** DO NOT include PHI or PII that may violate another individuals HIPAA rights.

[Top of the Document](#TopOfDoc)

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| PROVIDER CUSTOMER SERVICE |

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

[Top of the Document](#TopOfDoc)

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| Inappropriate Billing by Pharmacy (Claim Already Reversed) (PROVIDER CUSTOMER SERVICE) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

**ACTION** A review of the beneficiarys prescription claim history shows a claim for the drug was processed and reversed at the <<**PHARMACY NAME**>>. The beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Inappropriate Billing by Pharmacy (Pharmacy Needs to Reverse Claim) (PROVIDER CUSTOMER SERVICE) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



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

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

The Plan contacted the pharmacy in regards to the beneficiarys concerns. The pharmacy representative successfully reversed the claim. The beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Retail Pharmacy Issues (PROVIDER CUSTOMER SERVICE) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied with <<**PHARMACY NAME**>> because <<**REASON**>>.

**ACTION** The Plan contacted the pharmacy and spoke with a pharmacy representative regarding the beneficiarys 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 beneficiary and apologized for any inconvenience or frustration the beneficiary experienced. The beneficiary was additionally provided with a list of retail pharmacies near their residence.

[Top of the Document](#TopOfDoc)

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| Refused to Fill Controlled Substance (PROVIDER CUSTOMER SERVICE) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that <<**PHARMACY NAME**>> refused to fill <<**MEDICATION**>>.

**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 fill prescriptions when exercising sound professional and clinical judgment. The Plan apologized for any dissatisfaction this may have caused.

[Top of the Document](#“TopOfDoc”)

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| TECHNOLOGY |

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

[Top of the Document](#TopOfDoc)

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

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

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

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

[Top of the Document](#TopOfDoc)

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| Calls Not Made by Live CCR (TECHNOLOGY) |

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

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

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

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 beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Caller ID (TECHNOLOGY) |

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

**ACTION** The beneficiary was educated that outbound calls are placed by an Interactive Voice Response IVR system specializing in healthcare communications. The Caller Identification ID 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 beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Outbound Interactive Voice Response (IVR) Pin Number (TECHNOLOGY) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary is dissatisfied that the Interactive Voice Response IVR system provided a pin number instead of the medication information.

**ACTION** The beneficiary was educated that the Plan uses a secured IVR system to communicate with beneficiaries 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 PHI. If an answering machine is reached, a message is left with a toll free number to contact the Plan and a Personal Identification Number PIN for the beneficiary 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 beneficiary. The beneficiary 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 beneficiary requested to update their messaging preference:**

Per the beneficiarys request, their messaging preference was updated to be notified via <<**TEXT**>> <<**EMAIL**>>.

[Top of the Document](#TopOfDoc)

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| Inbound IVR Dissatisfaction (TECHNOLOGY) |

**REASON** The beneficiary expressed dissatisfaction with the Interactive Voice Recognition IVR system.

**ACTION** No CCR action required.

**RESULT** Plan provided useful tips when using the IVR. Plan recommended that the beneficiary keep background noise to a minimum, saying zero instead of the letter O. Plan further suggested that the beneficiary 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 beneficiarys responses may vary based on coverage area and signal strength.

When contacting the IVR, the system will say to the beneficiary, Tell me how I may help you. At this time, the beneficiary 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 DOB. The beneficiary 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 beneficiary, the Plan must authenticate a call when using the IVR. At times, the beneficiary may enter information into the IVR that is not translated fully processed in the main system. For the beneficiarys protection, the Customer Care Representative may have to ask the beneficiary to repeat their information in order to ensure they are speaking to the correct beneficiary.

The IVR includes an option for the beneficiary to add their phone number to the IVR database for future reference and identification purposes. When a beneficiary calls into the IVR from a phone number that is not in the IVR database, the IVR will ask I see you are calling from NUMBER, would you like to add this phone number to your account? Pause Please say either Yes or No. If the beneficiarys response is Yes, the IVR automatically adds the phone number to the IVR database after full authentication.

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.

[Top of the Document](#TopOfDoc)

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| Hold Music (TECHNOLOGY) |

**REASON** The beneficiary 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 beneficiaries on hold during a call so research can be performed or to consult with another department to resolve the issue. The beneficiary may also need to be transferred to a different department who can specialize in resolving the issue. However, the beneficiary will be placed on a brief hold during the transfer.

The Plan apologized for the hold musicand for any frustration this may have caused. To avoid long wait times, it is recommended to call during nonpeak hours such as early in the morning or in the evenings.

[Top of the Document](#TopOfDoc)

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| Dissatisfaction with Outbound IVR Not Providing Medication Name, Strength, or Quantity (TECHNOLOGY) |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**REASON** The beneficiary expressed dissatisfaction with the Interactive Voice Recognition IVR not providing the medication name, strength, or quantity.

**ACTION** When making an outbound IVR call, the Plan does not know who may pick up the phone call. Therefore, no medical information will be provided without their permission.

**RESULT** The Plan advised the beneficiary that the Health Insurance Portability and Accountability Act HIPAA provides data privacy and security provisions for safeguarding medical information, including medication specific information. The Plan advised the beneficiary that if they want to receive the name of the medication they can elect to receive messages via email.

On <<**XX/XX/XXXX**>>,thePlan changed the beneficiarys CMP alerts email to include the medication specific information per the beneficiarys request.

[Top of the Document](#TopOfDoc)

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| IVR Providing Information in Spanish (TECHNOLOGY) |

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

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

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

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

**RESULT** The Plan educated the beneficiary 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.

[Top of the Document](#TopOfDoc)

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| Difficulty Ordering Medications on caremark.com (TECHNOLOGY) |

**REASON** The beneficiary expressed dissatisfaction with the difficulty of ordering medications on caremark.com.

**ACTION** The beneficiary was educated on how to order renew prescriptions online. When ordering renewing medications on the Plans website, go to the Prescription tab, click view refill all prescriptions, click add to cart next to the prescription available for refill 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 beneficiary was encouraged to contact Customer Care for any future inquiries they may have.

[Top of the Document](#TopOfDoc)

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| When Above Templates Do Not Apply |

FILL IN THE BENEFICIARY SPECIFIC INFORMATION BETWEEN THE <<**SYMBOLS**>>.



**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 beneficiary calls.
* Include background information for the beneficiarys 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, beneficiary 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 what you did next if the issue was not resolved (i.e., transferred call to another department).

[Top of the Document](#TopOfDoc)

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