



04/03/2014

### **Hospice and Part D – Questions and Answers**

On March 10, 2014 the Centers for Medicare & Medicaid Services (CMS) released final guidance to hospice providers and Part D plan sponsors, [Part D Payments for Drugs for Beneficiaries Enrolled in Hospice – Final 2014 Guidance](#). The effective date of the prior authorization (PA) policy outlined in the memo is May 1, 2014 and will be applied prospectively.

Until then, the Part D plan sponsors are able to continue or initiate other processes to ensure that Part D is not billed for drugs that should be covered under Medicare Part A via the Medicare Hospice Benefit or that should be paid for by the beneficiary.

#### **What Is Prior Authorization?**

The PA process is a determination of payment responsibility for drugs for hospice beneficiaries. There are three scenarios for payment responsibility

1. The hospice pays for drugs covered under the Hospice Benefit
2. The beneficiary pays for the drugs
3. The sponsor pays for the drugs covered under the Part D Benefit

Sponsors will look to the prescriber or the hospice to provide an explanation of why a drug is unrelated to the hospice principal diagnosis/related conditions and should be covered by Part D. Per Medicare policy, the sponsor is to accept the explanation provided by the prescriber or hospice. The explanation can be verbal or written.

#### **Are All Medications for a Hospice Patient Subject to the Part D PA Process?**

Only medications that the patient and/or hospice believe should be covered by Part D are subject to the PA process.

#### **Who Can Provide the Explanation for the PA?**

The prescriber or the hospice can provide the explanation. Providing the explanation is not the same as initiating a PA. Only the beneficiary, their representative, or the prescriber can initiate the request for a PA. However, a

hospice can and should contact the Part D plan sponsor as soon as it knows the patient is a Part D enrollee to provide hospice enrollment information to the Part D plan and to provide a list of medications that should be covered by Part D and an explanation of why these medications are unrelated to the principal hospice diagnosis and related conditions.

**Note:** If the prescriber is not affiliated with the hospice (i.e. not employed, volunteering, or under arrangement), CMS policy is that the sponsor will require an attestation from the prescriber attesting that he/she has coordinated with the hospice to confirm the drug(s) is unrelated.

### **Does Hospice Have to Pay for ALL Medications?**

No, hospice does not have to pay for ALL medications. Hospices are reminded that they are responsible for all medications that are related to the principal hospice diagnosis and related conditions and that are reasonable and necessary for the palliation and management of the terminal illness and related conditions. This includes medications the patient may have been on for some time prior to the election of hospice care as well as new medications. It also includes medications that may not be on the hospice's formulary.

A beneficiary is liable for medications that are not reasonable/necessary for the palliation and management of the terminal illness and related conditions. These could be medications the patient insists on taking that the hospice interdisciplinary group (IDG) has determined are no longer effective in the intended treatment and/or may be causing additional negative symptoms. These could also be brand name drugs where the patient refuses to try the generic equivalent that is on the hospice's formulary and there are no medical reasons to indicate that the generic drug cannot/should not be taken.

The Part D plan sponsor pays for the drug when it is completely unrelated to the terminal illness and related conditions. CMS expects that this will be unusual and occur only in exceptional circumstances. To be clear, CMS is not making it a policy that ALL medications are to be covered by the hospice.

### **Does Hospice Have to Provide an ABN for Drugs It Is Not Paying For?**

Per the March 10, 2014 memo from CMS the hospice is not responsible for providing an ABN to the beneficiary in these cases unless the hospice is actually providing the drug to the beneficiary. If the hospice provides the drug even though it is not reasonable and necessary it must provide the ABN in order to charge the patient for the drug.

If the hospice does not provide the drug it still must fully inform the beneficiary of his/her liability (please see **SAMPLE Part D and Hospice Admission Notice** or **Part D Current Patient Letter SAMPLE**). If the beneficiary feels Medicare should cover the drug, he/she can submit an appeal directly to Medicare. Sponsor-specific appeal information should be provided by the sponsor through the pharmacy.

The Medicare Part D patient rights form that explains how a beneficiary can file an appeal is Form CMS -10147 and can be found at

<http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html>.

### **Is There a PA Form The Hospice Must Complete?**

For written explanations, it is expected that the Sponsor have a PA Form. CMS provides a checklist to the sponsors of the information the sponsor should include on a PA form (see <http://www.nahc.org/assets/1/7/PartDPaymentHospice13.pdf>), but during 2014 each Part D plan can develop its own form. If the sponsor develops its own form, it should use the form only for hospice PA purposes.

The Sponsor can accept verbal or written explanation. The Sponsor can also receive written information via FAX, delivery, or mail. In the interest of time, a FAX or hand delivery is suggested for written explanation.

### **What Happens When the Patient Picks Up/Orders Their Part D Meds?**

When the Part D plan sponsor receives a claim for drugs for a hospice beneficiary it will automatically send the requesting pharmacy a “reject code”. The pharmacy will notify the beneficiary, inform the patient that Part D will not cover the medication(s) unless information is received that indicates the medication(s) is not related to the hospice principal diagnosis and related conditions. The beneficiary can request the PA process be followed or pay for the medication(s).

### **How Much Time Does the Sponsor Have to Make a Payment Determination?**

The clock starts ticking when the sponsor receives the PA explanation from the prescriber of the hospice. The timeframes are

- 24 hours for an expedited review
- 72 hours for a standard review

If the sponsor believes it needs additional information, it may request it, which could extend these timeframes, provided, however, that it is not extended unreasonably. The beneficiary can request an expedited review. NAHC encourages hospices to suggest to all their patients that an expedited review be requested.

### **How Much Time Does the Prescriber or Hospice Have to Provide an Explanation?**

CMS expects the prescriber or hospice will respond as quickly as possible to the sponsor’s PA request. No specific timeframes are prescribed by CMS.

### **Does Hospice Have to Provide a Copy of its Formulary to the Sponsor?**

No. In fact, the hospice’s formulary is not a list of medications that the hospice covers for each patient. It is a list of medications the hospice *could* cover for a patient. Each medication coverage decision is to be evaluated based on the patient’s unique situation.