

National Association for Home Care & Hospice/Hospice Association of America



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Hospice and Part D – Questions and Answers

On July 18, 2014, the Centers for Medicare & Medicaid Services (CMS) released revised guidance to hospice providers and Part D plan sponsors, [Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice](#). This guidance replaces that previously laid out by CMS (see March 10, 2014 [Part D Payments for Drugs for Beneficiaries Enrolled in Hospice – Final 2014 Guidance](#).) The effective date of the prior authorization (PA) policy outlined in this most recent memo is immediate with the expectation that all Part D sponsors will have it in place no later than October 1, 2014. IT IS ANTICIPATED THAT PART D PLANS WILL IMPLEMENT THE POLICY WITHIN DIFFERENT TIME FRAMES; FOR THIS REASON IT IS IMPORTANT WHEN HOSPICES MAKE OUTREACH TO PLANS THAT THEY ASCERTAIN WHETHER THE PLANS HAVE TRANSITIONED TO THE NEW POLICY. The guidance is just that – guidance – and it is in effect until something more permanent is identified. In essence, this means that because the guidance is not a regulation CMS cannot enforce it but CMS does strongly encourage both Part D plans and hospices to abide by the guidance and has built the policy with incentives to do so in mind.

What Is The 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?

CMS instructs the Part D plan sponsors to place beneficiary-level PA requirements on only four classes of drugs for beneficiaries who have elected hospice to determine whether the drugs are coverable under Part D. These four classes are:

- analgesics,
- antinauseants (antiemetics),
- laxatives, and
- antianxiety drugs (anxiolytics).

CMS expects that most of the medications in these categories would be related to a hospice patient's principal diagnosis or related conditions so it would be a rare occurrence that one of these types of medications would be submitted to the Part D plan for payment for a hospice beneficiary.

Who Can Provide the Explanation for the PA?

The prescriber or the hospice can provide the explanation. Hospices are no longer required to provide a statement of explanation to the Part D sponsor as to why a medication is unrelated or is not reasonable/necessary. CMS is encouraging use of a standardized two-page [form](#) (Hospice Information for Medicare Part D form) on which to communicate drug information. All Part D plans should accept the form and the information contained on it, but CMS is not requiring use of the form.

Listing the drug on the new standardized form tells the sponsor that the drug is unrelated to the hospice principal diagnosis and related conditions and should be covered under the Part D plan. The form provides space for a rationale to support the drug is unrelated; however, clinical justification for that determination is optional. To be clear, while hospices must specify that a drug is unrelated or related to the terminal illness or related condition(s), hospices are no longer required to make a verbal or written statement to the Part D sponsor as to why a medication is unrelated or is not reasonable/necessary. However, hospices are required to have the documentation to support such a decision in the patient's medical record.

How Can Hospice Expedite the PA Process for the Beneficiary?

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. Likewise, the hospice should provide termination (discharge/revocation) information to the Part D sponsor as soon as possible. The sponsor may accept documentation of an election or termination from the hospice, the beneficiary, or the prescriber and can accept it in hard copy, mailed or FAXed.

The first page of the form can be used by the hospice to report only a beneficiary's hospice election or termination (discharge or revocation). There is a checkbox on the form for this purpose.

Acceptable documentation of a termination is as follows:

- Revocation:
 - Copy of the written statement the patient provides to the hospice indicating the desire to revoke and the effective date of the revocation (i.e. revocation form)
 - Proof of submission of a final hospice claim indicating the date of revocation
 - Discharge for no longer being eligible for hospice care: Copy of the Notice of Medicare Non Coverage (NOMNC)
 - Discharge for cause or transfer out of service area: copy of the hospice discharge summary
- OR
- Page 1 of the standardized hospice prior authorization form

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.

CMS is strongly encouraging hospice providers to supply a compassionate "first fill" for any medication needed by a beneficiary who is experiencing difficulty in accessing the drug at point of sale (POS). If the drug provided is unrelated to the terminal illness and related conditions, the hospice provider should contact the Part D sponsor to negotiate recovery of the hospice's payment to the pharmacy at a later date.

A beneficiary is liable for medications that are not reasonable/necessary for the palliation and management of the terminal illness and related conditions.

The Part D plan sponsor pays for the drug when it is completely unrelated to the terminal illness and related conditions only.

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. If the beneficiary believes 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?

CMS is strongly encouraging use of a standardized two-page [form](#) (Hospice Information for Medicare Part D form). All Part D plans should accept the form and the information contained on it, but CMS is not requiring use of the form.

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 that fall within the four classes of drugs subject to PA, 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 unrelated to the hospice principal diagnosis and related conditions. The beneficiary can request the PA process be followed or pay for the medication(s).

If the hospice has already supplied the pharmacy/sponsor with the completed Hospice Information for Medicare Part D form, the pharmacy can use this to override the reject codes and provide the medications to the beneficiary.

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 that the prescriber or hospice respond as quickly as possible to the sponsor's PA request. No specific timeframes are prescribed by CMS. A sponsor may request an explanation within a certain timeframe.

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.