STANDARD OPERATING PROCEDURE

GlobalHealth	**Department** Pharmacy	**SOP #** RX-083-M	
	Title Part B Drug Transition Period	**Related Policy #**	
	Implementation Date 01/01/2024	**Review Cycle** Annual	**Last Revised** **12/14/2023**

Policy

The minimum 90-day transition period prohibits an MA plan from disrupting or requiring reauthorization for an active course of treatment for new plan enrollees for a period of at least 90-days (or the course of treatment has concluded, whichever comes first). The MA plan cannot deny coverage of active courses of treatment on the basis that the active course of treatment did not receive prior authorization (or was furnished by an out-of-network provider) but may review the services furnished during the active course of treatment against permissible coverage criteria when determining payment.

Purpose

To ensure that GlobalHealth is in compliance with all regulations for the 90-day transition period for medications requested to be covered under a new enrollee's medical benefit (Part B) as defined by Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS) Final Rule (CMS-4201-F).

Training

1. New hires are trained during orientation and through peer training.
2. Staff is notified of updates and changes to policy through departmental meetings and/or email notification with additional training provided as needed.

Procedure

1. Overview:
    a. GlobalHealth does not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days, when enrollee currently undergoing treatment switches to a new MA plan, even if the course of treatment was for a service that commenced with an out-of-network provider.
    b. The 90-day transition period begins the day enrollment in the new plan becomes effective,
    c. Who is eligible for a Part B drug transition: all new enrollees* who are undergoing an active course of treatment —including where the active course of treatment is taking a physician-administered drug covered under Part B.
        i. New Enrollees are those:

1. New to an MA coordinated care plan having either been enrolled in a different MA plan with the same or different parent organization, or;
2. An enrollee in Traditional Medicare and joining an MA coordinated care plan, or;
3. Beneficiaries new to Medicare and enrolling in an MA coordinated care plan.

ii. An active course of treatment is one in which a patient is actively seeing the provider and following the course of treatment. (§ 422.112(b)(8)(ii)(B))

d. After 90 days GlobalHealth will reassess medical necessity through a prior authorization and apply out-of-network limits in accordance with plan benefits and other relevant requirements as appropriate.

2. Intake- Pharmacy Administrative Coordinator receives a request for a Part B Drug.
   a. Pharmacy Administrative Coordinator will validate member eligibility in HealthAxis to verify if the patient is new to GlobalHealth and possibly eligible to receive a transition fill.
      i. If the patient is new enrollee, the Pharmacy Administrative Coordinator will note the coverage effective date in the Decision and Routing Information Notes and route the authorization request to the appropriate queue (Technician or Pharmacist).
      ii. If the patient is not a new enrollee, the Pharmacy Administrative Coordinator will route to the appropriate queue (Technician or Pharmacist) to continue with the prior authorization process for initial organizational determination in accordance with GlobalHealth's Part B UM SOP.
3. Evaluation of Evidence
   a. The Pharmacy Administrative Coordinator or Pharmacist will prioritize any case classified as Part B Transition Fill because these authorization requests do not require a clinical evaluation.
   b. The Pharmacy Administrative Coordinator or Pharmacist must perform a second eligibility review and confirm eligibility within HealthAxis
   c. Once eligibility for Part B Transition is confirmed, proceed to review the information received to confirm the patient is receiving an active course of treatment (e.g., Medication Administration Record, progress notes).
   d. If the above information is not already available, the Pharmacy Administrative Coordinator must proceed with:
      i. One outreach intervention with the doctor and/or patient and request evidence of active treatment to attach to the case.
      ii. If the information is not provided by at least 18hrs the case will be evaluated as initial organizational determination.
   e. If the above information is received to confirm active treatment, Pharmacy Administrative Coordinator will upload the document as an attachment to the authorization request in HealthAxis. The Pharmacy Administrative Coordinator will then proceed with the approval of the Part B Drug

transition fill for up to a maximum of 90 days of treatment within the member's first 90 days of transition.

References

1. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS), DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) FINAL RULE (CMS–4201-F)
2. Medicare Advantage and Part D Drug Pricing Final Rule (CMS-4180-F) 42 CFR Parts 422 and 423
3. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective August 3, 2022)
    a. Section 10.5: Adjudication Requirements
    b. Section 20.1: Representatives
    c. Section 40 – Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations
    d. Section 80 - Reopening and Revising Determinations and Decisions.
4. Part C Organization Determinations, Appeals, and Grievances (ODAG) Program Area AUDIT PROCESS AND DATA REQUEST. OMB No: 0938-1000 (Expires: 04/30/2020) CMS-10191
5. Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans (Effective 01/01/2021)
6. HPMS Memo: Release of Medicare Advantage and Prescription Drug Plan Appeals Guidance (2/22/2019)
7. CMS HPMS Memo: CY 2022 Parts C & D Dismissal and Withdrawal Q's & A's, December 9, 2021

Definitions

1. Organization Determination: Any determination made by a health plan regarding any of the following:
    a. Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
    b. Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered, or, if not covered, should have been furnished, arranged for, or reimbursed by the health plan;
    c. The health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the health plan;
    d. Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; or
    e. Failure of the health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.
2. Pre-Service Organization Determination: GlobalHealth's determination regarding the items and/or services a member is entitled to receive under

their benefit plan when a request for the provision of health services is received prior to the service being delivered by a Provider. Some healthcare services are required to be pre-authorized (evaluated and approved by GlobalHealth prior to being accessed by the member in order for payment to be rendered).

3. Expedited Organization Determination for Part B Drugs: An enrollee, or any physician, may request an expedited organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. The determination must be rendered as expeditiously as the enrollee's health condition might require, but no later than twenty-four (24) hours after receiving the enrollee's request.
4. Standard Organization Determination for Part B drugs: A decision to authorize or deny a pre-service request for authorization of specific inpatient or outpatient medical services that must be rendered as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours after the date GlobalHealth receives the request.
5. Reconsideration: Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence, and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits, or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.

Review and Revision History

11/28/2023: Creation
12/14/2023: Revised