Eli's Hospice Insider

Coverage: Gear Up For Drug Coverage Appeals

High-profile press coverage could lead to more beneficiary medication coverage appeals.

Hospices can expect to hear more about beneficiaries appealing their coverage of items and services, thanks to a New York Times column on the court case brought by **Howard Back**, whose wife was under hospice care and denied Actiq (see Eli's Hospice Insider, Vol. 5, No. 9).

The fact that Medicare beneficiaries and their survivors have a right to appeal denials of services by a hospice provider "wasn't at all clear until this court's decision," for the palliation and management of the terminal illness and related conditions, including interventions to manage pain and symptoms, and drugs and treatment necessary to meet the needs of the patient," CMS advises.

Then, "if the patient or representative does not agree with the hospice plan of care and refuses to accept medications prescribed to meet the assessed needs ... the hospice is required to document this in the clinical record," CMS adds.

Step 2: Proceed with the drug you cover. "In situations when the hospice has a drug on its formulary and the interdisciplinary group has decided to include that drug in the patient's plan of care, and when the patient/representative requests another drug that is equivalent but not on the formulary, the hospice is not required to immediately provide the requested drug," CMS explains. "Rather, the hospice is allowed to begin implementing the plan of care with the formulary drug."

Step 3: Document further. "The hospice is responsible for updating the patient's assessment and documenting the patient's progress the patient's desired outcomes," CMS notes. "The hospice is also responsible for updating the patient's plan of care based on the information gathered during the updated assessment."

Step 4: Make necessary modifications to the POC. "Hospices must adjust the plan of care to assure that it meets the patient's needs and helps the patient achieve his or her desired outcomes," CMS directs. "We expect hospices to choose non-formulary drugs when they are necessary to meet the patient's needs and desired outcomes."

CMS leaves it up to hospices to decide when they are providing adequate drug coverage. "CMS does not specify guidance or instructions on providing a brand name versus a generic medication. The hospice has the option to decide what medications it will carry on its formulary. However, all medications prescribed for a beneficiary must meet the needs of the beneficiary."

Step 5: Send the patient to the pharmacy. "If a beneficiary requests a certain medication that a hospice can't or won't provide, the hospice can give the beneficiary a prescription to have filled by a pharmacy separate from the hospice," CMS explains. "Since the hospice is not providing the medication, the hospice is not obligated to submit a claim or provide any notice of non-coverage (including the ABN)."

Step 6: Appeal. CMS stops short of telling hospices that they must explain the appeal process to beneficiaries. "However, if the beneficiary feels that Medicare should cover the cost of the drug, the beneficiary may submit a claim for the medication directly to Medicare on Form CMS-1490S," the agency details. "If the claim is denied, the beneficiary may file an appeal of that determination under the appeals process set forth in part 405, subpart I."

Note: The Q&A is at www.medicarenhic.com/RHHI/billing/HABNQA0717.pdf starting on p. 5 of the PDF file.

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