Long-Term Care Survey Alert

SURVEY MANAGEMENT: Be Survey Savvy: Master The Intricacies Of Managing Part D

Follow these steps from admission to exception requests.

Nursing facilities that don't have a systematic plan for meeting residents' pharmaceutical needs under Part D might as well hang a sign for the survey that reads: "Cite me."

The bottom line: Whether Part D pays for a drug is inconsequential to surveyors, cautions **Harvey Tettlebaum**, partner, **Husch & Eppenberger** in Jefferson City, MO. "Surveyors will cite facilities for failing to meet a resident's medication needs completely -- regardless of whether the resident has a negative outcome," he tells **Eli**. "They can cite for 'potential harm.'"

Don't move to Plan P (panic): Instead, use this step-by-step guide to ensure residents receive their meds -- and you don't end up with a fistful of unpaid bills and F tags.

Step 1: Compare each resident's medication regimen to his prescription drug plan's formulary to see if all the drugs are covered. "Each plan's formulary is different, so compliance will be a challenge," says **Joseph Hill**, manager of government affairs for the **American Society of Consultant Pharmacists.** (Part D does require coverage of certain classifications of drugs, however.)

Tip: Check a plan's formulary online at http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp.

Good question: What if you don't know what plan a dual eligible resident has been auto-enrolled in? Nursing homes can obtain that information from the Centers for Medicare & Medicaid Services by fax or mail (for under 100 residents) or mail for 101 or more dual-eligible benes. Download forms and instructions at www.mecf.org/upload_dir/LTC_Admin_Trans.pdf.

Step 2: Develop a systematic strategy for evaluating whether to switch a resident to a formulary medication or request the plan to grant an exception. There are certain classes of medications that you can readily switch, says **David Jones, RPh, FASCP**, an independent pharmacy consultant in Baltimore. "The consultant pharmacists will be familiar with these because they routinely collaborate [with facilities] in managing formularies under Medicaid or Medicare Part A days," he adds.

But don't switch residents from a drug, including an antidepressant, that has maintained them in a stable condition simply to comply with a formulary that may be driving use of a cheaper pill, cautions **Claudia Schlosberg**, an attorney with **Blank Rome LLP** in Washington, DC. Also keep in mind that changing a resident's medication can "create significant extra nursing, medical and other costs for nursing homes" -- and the risk of adverse drug reactions, she adds.

Step 3: Be prepared to submit a request to the plan for an expedited or standard exception determination. "A plan should cover a medication if a doctor says it's medically necessary -- and if another drug on the formulary won't maintain the person and treat his condition as effectively," says Schlosberg. Make sure you submit a physician statement to that effect with the exception request, she adds.

A plan has 24 hours to render a decision on expedited exception requests -- and 72 hours for a standard or non-expedited one.

What types of medication might warrant an expedited versus standard exception process? "An antibiotic or analgesic," should go on the fast track, Jones says, whereas "the 72-hour time frame might be [appropriate] for an antihypertensive."

To review the steps involved in the exceptions request and appeals process, see the chart later in this issue.

Step 4: Take advantage of the transition to Part D where plans should provide a supply of a resident's non-formulary medication to allow time for the exception process. "CMS has dictated that plans should provide a 'first fill' of at least 30 days to match the [nursing home] resident's existing medication regimen" in such cases, says Jones. The first fill applies to the first time a resident in a long-term care setting has an existing medication refill as he transitions from another setting or payer, he adds.

Some plans are offering more generous first fills for long-term care residents covering 60 to 90 or even 180 days in some cases, says Hill. For a summary of prescription drug plan (PDP) and Medicare Advantage Prescription Drug (MA-PD) transition policies, go to www.cms.hhs.gov/PrescriptionDrugCovGenIn.

If at first you don't succeed: If the plan's customer reps say they don't know what you're talking about when you call to ask about its transition policy, "have a copy of the CMS statement outlining the requirement available and push [the issue] with the plan," advises Jones.

Source: Here's a link to a CMS response to a question about "first fills": www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/EmerTLCFill.pdf.

Work with your pharmacy: "Facilities should talk with their pharmacies up front and get something in writing where the pharmacies agree to provide a drug during an expedited review or appeals process," counsels **Janet Potter**, a reimbursement specialist with **FR&R Healthcare Consulting** in Deerfield, IL.

Step 5: Educate residents and their representatives about their options for plans whose formularies cover their medication regimens. Some plans say they expect to be liberal in granting valid exception requests because they want to hold onto their enrollees, Schlosberg notes.

A caveat: The facility cannot tell residents they have to enroll in a new Part D PDP, cautions **Nancy Taylor**, an attorney with **Greenberg Traurig LLP** in Washington, DC. "The resident or his representative has to make a decision to do that," she says.

Dual eligibles may change plans at any time, says Schlosberg, although there can be a bit of a delay. For example, if a dual eligible beneficiary requested a plan change in January, it would go into effect Feb. 1, she says.

For more information on what constitutes "plan steering" under Part D, see the What Do You Think? included with this issue.

Tip: Make sure cognitively impaired residents have a representative to make decisions for them related to PDPs. An enrollee may choose an agent of the facility, such as a registered nurse or case manager, to act as his representative, according to CMS guidance.