PUBLIC SUBMISSION

As of: 7/7/16 12:04 PM
Received: June 17, 2016
Status: Posted
Posted: July 06, 2016
Tracking No. 1k0-8q95-s4dg
Comments Due: July 05, 2016
Submission Type: Web

Docket: CMS-2016-0071
(CMS-10185) Medicare Part D Reporting Requirements and Supporting Regulations

Comment On: CMS-2016-0071-0001
(CMS-10185) Medicare Part D Reporting Requirements and Supporting Regulations

Document: CMS-2016-0071-0002
CA

Submitter Information

Name: Colleen Matoon
Address:
San Diego, CA, 92131
Email: colleen.matoon@medimpact.com
Organization: MedImpact, Inc.

General Comment

1. The following fields were listed on the crosswalk between the 2016 requirements to the 2017 requirements as revised, saying that technical clarification had been provided. Since the technical specs weren't released with the documents, we don't know what the revisions are, so are unable to provide useful comments:

Total Number of Grievances
Number of Expedited Grievances
Other Grievances
Coverage Determinations and Exceptions: 1 K-S
Redeterminations: 2 A-G
Coverage Determinations and Redeterminations: Reopenings: 4: Date of original disposition
Coverage Determinations and Redeterminations: Reopenings: 7: Date case was reopened

2. Will the "Improving Drug Utilization Review Controls" report be included in Data Validation audits?

3. In the "Improving Drug Utilization Review Controls" report, the instructions for data element "H" state "Of the total reported in element F, the number of soft edit claim rejections overridden at the pharmacy level by the pharmacist submitting appropriate NCPDP codes.". Can CMS define "appropriate NCPDP codes"?

4. Since CMS is considering the opioid MED edit as a coverage determination, should these coverage determination be included in the Coverage Determination reports?

5. Please provide examples of how CMS expects the table to be completed in the technical specifications.

6. for Part V on P. 13: Element H
We expect situations where the pharmacist can not submit an override code (usually for technical reasons), or does not want to (e.g. pharmacist observes suspicious behavior,is missing info, etc.).

In the first case, we expect the call center to enter the pharmacist's override code into the system, and these will be captured in Element H.

If the pharmacist chooses not to override, and the member contacts us, this would (today) trigger a coverage determination process. Is that appropriate? And if so, would we be expected to report these in Element H, or Element S?