POLICY AND PROCEDURE	
Title: Part D Coverage Determinations and Redeterminations	
Primary policy owner: Pharmacy	**Policy #:** PH45
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☐Behavioral Health & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☐ Case Management (CM) 5) ☐ Claims (CLMS) 6) ☐ Community Marketplace & Member Engagement (MAR) 7) ☐ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☐ Cultural & Linguistics (CL) 11) ☐ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☒ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☐ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☐ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
Product Type: ☐Medi-Cal ☒D-SNP	**Supersedes Policy Number:** NA

I. PURPOSE

To ensure Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") is in compliance with all contractual requirements, applicable federal and state laws, and regulations for responding, preventing, reviewing, and investigating all reported and identified non-

compliance. Health plan workforce and Delegates administer Part D Coverage Determinations (CDs) and Redetermination processes in compliance with federal and state regulations and other program requirements.

II. POLICY

A. Health Plan must implement a Coverage Determination and Redetermination process that follows Centers for Medicare and Medicaid Services (CMS) latest regulations. Health Plan must administer this process through its Pharmacy Benefit Manager (PBM).

B. PBM must be available to receive coverage determinations, redeterminations, and reimbursement requests twenty-four (24) hours per day, seven (7) days per week, and including holidays.

C. PBM must have the ability to receive requests from members (or appointed representative) and prescribing physicians via phone, fax, or website.

D. PBM must ensure that requests are categorized appropriately (for example: initial request versus redetermination, formulary coverage determination versus exception request).

E. PBM must review the requests within the appropriate timelines:
   1. Coverage determinations: 72 hours for standard requests, 24 hours for expedited requests.
   2. Exception requests: upon receiving prescriber's supporting statement: 72 hours for standard requests, 24 hours for expedited requests.
   3. Payment requests: 14 calendar days.
   4. Redetermination requests: 72 hours for expedited requests and 7 days for standard requests.

F. PBM must use CMS approved prior authorization (PA) criteria for coverage determination requests.

G. PBM must perform outreach to the prescriber if additional information is needed to review a coverage determination, redetermination, or

exception review cases. At least one attempt to obtain additional information must be required when necessary.

H. PBM must effectuate approved coverage determinations and overturned redeterminations in a timely manner upon conclusion of the review.
I. PBM must notify enrollees and physicians timely and in writing of the determination of the case. Members must be notified verbally and issued a written notification letter.
J. Untimely cases must be forwarded to the Independent Review Entity (IRE) assigned by CMS within the regulatory timelines.
K. PBM must effectuate overturned decisions by Independent Review Entity (IRE), Administrative Law Judge (ALJ), or Medicare Administrative Contractor (MAC), no later than 72 hours after receipt of the notice reversing the determination.

III. PROCEDURE

A. The PBM provides Health Plan the following:
    1. Coverage Determination Logs: (records of all coverage determination requests, decisions, and rationales).
    2. Quality Assurance Reports: (records of internal reviews or audits of the coverage determination process).
    3. Upon request by Health Plan, its Decision-Making Criteria (guidelines and criteria used for making coverage determinations).
    4. Annually: Decision-Making Criteria (guidelines and criteria used for making coverage determinations).
B. In the event of an audit, PBM provides the appropriate audit universes as specified in CMS audit protocol and attends the audit to answer questions.
C. Prior to every benefit year, the PBM provides its standard approval and denial template letters for coverage determinations for Health Plan's review and approval for all possible coverage determinations categories (non-formulary, prior authorization, step-therapy, tier exception, reimbursement etc.) as well as redetermination template letters before the 4th quarter of the year preceding the benefit year. PBM uses the CMS model letter whenever possible.

D. PBM prepares CMS annual reports titled "Coverage Determination, Redeterminations (including At-Risk Redetermination under a Drug Management Program), and Reopening's" based on technical guidance released by CMS annually. The reporting period is January 1 to December 31 of the previous year and is provided to Health Plan in January of the year in which it is submitted to CMS.

E. Oversight and Monitoring
Health Plan reviews Coverage Determination Logs daily and check for:
   1. Timeliness of the determinations and effectuations.
   2. Timeliness of the notifications to the member and prescriber.
   3. If not reviewed timely, the case was forwarded to IRE within appropriate timelines.
   4. Correct PA type.

F. Health Plan audits weekly select samples of coverage determinations for in depth clinical review, specifically:
   1. Case documentation to ensure clarity and completeness.
   2. Appropriate decision making based on clinical information.
   3. Review of the language of notification letter to the member and appeal rights provided in denial notifications.

G. For redetermination cases, when the issue is a denial of coverage based on a lack of medical necessity, Health Plan verifies that the redetermination is made by a physician with expertise in the field of medicine that is appropriate for the services at issue.

IV. ATTACHMENT(S)

A. Glossary of Terms Link

V. REFERENCES

A. 42 CFR § 423.582(a-c), 42 CFR § 423.586
B. 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F)
C. 42 CFR §423.153(d)
D. Title 42, Part 423, Subpart M
E. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance https://www.cms.gov/medicare/appeals-and-

grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

F. Medicare Part D Reporting Requirements https://www.cms.gov/files/document/cy2025-part-d-reporting-requirements-08152024.pdf
G. §§ 422.568(g), 422.631(e), and 423.568(i)
H. State Medicaid Agency Contract (SMAC)
I. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

VI. REVISION HISTORY

Version*	Revision Summary	Date
001		
002		
003		
004		
Initial Effective Date: 09/24/2025		
Published Date:09/29/2025		

VII. Committee Review and Approval To Be Completed by Compliance

Committee Name	Version	Date
Compliance Committee	001	09/24/2025
• Privacy & Security Oversight Committee		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review Committee		
Quality Improvement Health Equity Committee (QIHEC)		

• Quality Operations Committee		
• Grievance Committee		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare Services (DHCS)			
Department of Managed Care (DMHC)			

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy