



CALIFORNIA HEALTH ADVOCATES

When Your Part D Prescription is Denied

With the many different kinds of issues or problems you may encounter with your Medicare prescription drug plan, there are several levels of action available to you:

- Coverage Determinations
- Exceptions
- Appeals
- Complaints/Grievances

Note that complaints/grievances are not part of the appeals process discussed below. They are for complaints about your Part D plan that don't involve coverage or payment issues.

Coverage Determinations

If your pharmacist tells you that your Medicare drug plan won't cover a drug you think should be covered, or it will cover the drug at a higher cost than you think you are required to pay, you have the right to:

- Request a decision called a "Coverage Determination" from your plan. Request this if your plan tells you that:
 - You must get prior approval first for your drug
 - You must try another drug before it pays for the drug first prescribed for you
 - There is a limit on the quantity or dose of the drug prescribed
 - And you or your doctor disagrees with any of the above.
- Pay for the prescription and request that the plan pay you back by requesting a coverage determination.

You, your doctor, family member, or other appointed representative can contact your plan to request the plan cover the prescription you need. You can call or write a letter to make this

request. Once the request is received, the plan has 72 hours or 24 hours to notify you of its decision, depending on the type of request made:

Standard Request: The plan will have 72 hours to respond if you have submitted a standard request for coverage or a request to pay you back.

Expedited Request: The plan may have 24 hours to respond if you have submitted an "expedited request" for coverage. The request will be expedited if your doctor tells your plan that your life or health will be seriously jeopardized by waiting for a standard decision. It can also be expedited at the discretion of the plan if you yourself request the faster review, but don't have your doctor's support.

The plan may first notify you of its decision within 24 hours by telephone. It must also mail you a written expedited coverage determination letter within three calendar days after it verbally informs you of its decision.

If the plan does not give you a written notice about its expedited determination within these timeframes, it must send your request for expedited coverage determination to the Independent Review Entity (IRE). This is discussed in Step 2 in the appeals process outlined below.

Exceptions

An "exception" is a type of coverage determination. It is a request for a coverage determination that requires you to submit a supporting statement from your doctor. It must explain why you need the drug you are requesting.

You may request an exception if:

- You are taking a drug that has been removed from the formulary;

- A non-formulary drug is prescribed and is medically necessary;
- The co-payment for a drug you are using changes and you cannot afford the new amount you are required to pay;
- You are asking for the plan to cover a non-preferred drug at the preferred drug cost.

In general, an exception request must be granted: 1) if the plan determines that the medication is “medically necessary;” and 2) if for at least one of these three situations your prescribing doctor determines:

- That none of the drugs on the formulary would be as effective as the non-formulary drug
- That any other drug would have adverse effects
- That the plan’s preferred drug for the treatment of the condition would not be as effective as the prescribed drug or would have an adverse effect.

Note: Medicare prescription drug plans use a system of tiers to apply a co-payment to a particular drug. Generic drugs on a plan's preferred list will usually have the lowest co-payment while drugs on the plan's non-preferred list will be on a higher tier and will have higher co-payments.

Once an exception is granted, it remains in effect for the calendar/plan year (as long as your doctor prescribes it). If you renew your enrollment in the same Medicare drug plan at the end of the year, you may be required to submit a new exception request for the next year.

If the drug plan denies you coverage, the plan must notify you (and your doctor, if he or she is the one who made the exception request) in writing within 72 hours. It must explain the reason for the denial and how to continue in the appeals process.

Appeals

If the plan issues a coverage determination or exception that is not in your favor, you can appeal that decision. When you join a Medicare drug plan, the plan will send you information about the plan's appeal procedures. Keep this information where you can find it in case you

need it. You can also call your drug plan for this information.

There are five levels of appeal available, outlined below.

Step 1: Redetermination by Plan

The first step in the appeals process is through your drug plan. You must request this appeal within 60 calendar days from the date of the coverage determination (though the time period can be extended if you can show good cause why you filed late). You, your appointed representative, or your doctor must file a request in writing unless your plan accepts telephone requests.

Your request will be expedited if your plan determines, or if your doctor tells your plan, that your life or health will be seriously jeopardized by waiting for a standard decision. Once your plan receives your request, the plan has seven days (standard) or 72 hours (expedited) to notify you of its decision.

Step 2: Reconsideration by Independent

Review Entity (IRE)

If you are dissatisfied after the Redetermination, you can request the next review by an Independent Review Entity (IRE). You must make a standard or expedited request within 60 days from the date of the decision. Your request will be expedited if the IRE determines, or if your doctor says that your life or health will be seriously jeopardized by waiting for a standard decision. The request must be in writing and sent directly to the IRE.

Once the request is filed, the IRE has seven days (standard) or 72 hours (expedited) to notify you of its decision. The IRE is required to ask your prescribing doctor for his or her opinion about the appeal and they must include a written account of the doctor's input in the redetermination documentation.

The IRE in California is called Maximus CHDR (Center for Health Dispute Resolution) and more information can be found at their website: medicarepartdappeals.com.

Step 3: Hearing with an Administrative

Law Judge (ALJ)

If you are not satisfied with the Reconsideration decision, you can request a hearing with an ALJ from the federal Department of Health and Human Services. You must request the hearing in writing within 60 days of the IRE decision.

You must send the request to the entity specified in the IRE's reconsideration notice. To receive an ALJ hearing, the projected value of your denied coverage must meet a minimum dollar amount. (You may be able to combine claims to meet the minimum.) In 2008, the minimum is \$120 (this amount will usually go up each year). The IRE's decision should include this amount.

Once the request has been received, the ALJ generally has 90 days to make a decision, though this timeframe can be extended for several reasons, including submission of new evidence or if you request an in-person hearing. Hearings are generally done over the phone or through video-conference.

There are several ways to meet the required dollar amount:

- Use the projected value of the drug (or drugs) in question over the course of the calendar year
- Combine two or more of your appeals
- Two or more appeals by several different people (who are all in the same drug plan) can be combined if they all involve the same drug

Step 4: Review by the Medicare Appeals

Council (MAC)

If you are dissatisfied after the ALJ's decision, you can request a review by the MAC. You must make the request in writing to the MAC within 60 days from the date of the notice of the ALJ's decision. The MAC generally has 90 days to make a decision after receiving the request. Normally, there will be no hearing during this stage of appeal.

Step 5: Review by a Federal Court

If you are still dissatisfied, you can request a review by a Federal court. You must make the

request in writing within 60 days of the date of the notice of the MAC's decision.

You must send your request to the entity specified in the MAC's decision notice. To receive a Federal court review, the projected value of your denied coverage must meet a minimum dollar amount (for example, \$1,180 in 2008). The MAC's decision will include this amount.

Note: You should consider seeking legal advice before appealing to an administrative law judge, the Medicare Appeals Council, or Federal Court.

Complaints/Grievances

If you have a complaint about your Medicare drug plan that doesn't involve coverage or payment, you have the right to file a complaint (also called a "grievance").

You should file your complaint within 60 days of the event that led to the complaint. Complaints can come from dissatisfaction with any aspect of a drug plan's operations, activities, or behavior. Examples of why you might file include:

- You have to wait too long for your prescriptions
- The plan did not make a decision within the required timeframes
- You believe your plan's customer service hours of operations should be different
- You cannot speak to a customer service representative in your preferred language
- The pharmacy is charging you more than you think you should have to pay (In this case, call the drug plan to get the most up-to-date price)

If the plan doesn't take care of your complaint, call 1-800-MEDICARE (or 1-800-633-4227).

The plan must notify you of its decision within 30 days after receipt of the complaint/grievance, though this timeframe can be extended at your request or if the plan can show that a delay would benefit you.

Grievances related to the quality of care you receive must be responded to in writing, and must include a description of your right to file a written complaint.

Quality of care complaints can also be filed with Lumetra, the Quality Improvement Organization (QIO) in California, at 1-800-841-1602, or 1-800-881-5980 (TDD for the hearing impaired). See lumetra.com.

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The Health Insurance Counseling and Advocacy Program (HICAP) provides free, objective information and counseling on Medicare and other related topics. You can call **1-800-434-0222** with your questions or to make an appointment at the HICAP office nearest you. To find the HICAP office in your area, visit cahealthadvocates.org