CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Prescription Drug Coverage: How to Request a Coverage Determination, File an Appeal, or File a Complaint

There are two ways to get Medicare prescription drug coverage:

1) **Medicare Prescription Drug Plans (Part D)**
   These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.

2) **Medicare Advantage Plans (like an HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage**
   You get all of your Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), and prescription drug coverage (Part D) through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs."

Medicare doesn't cover (pay for) all prescription drugs. Each Medicare drug plan has its own list of drugs (called a "formulary") that are covered by the plan. The formulary will include generic and brand-name drugs. The plan's formulary must meet Medicare's requirements. Check to see if the plan covers your prescription drugs.

Even if a drug is on the plan's list, there may be special rules for filling a prescription. For example, you or your prescriber may need to get permission from the plan (prior authorization) to use the drug before it is covered. The plan may ask you to try another drug before it will cover the drug that was prescribed for you. Also, the plan may limit the number of pills or dose prescribed.

In addition to these special rules, the plan's formulary can change during the year because drug therapies change, and new drugs and medical knowledge become available. If there is a formulary change that affects a drug you take, your plan will notify you at least 60 calendar days in advance. You will then have an opportunity to request an exception. See the next page for more infomation.

There may be times when you disagree with a coverage or payment decision made by your Medicare drug plan. This publication explains your options and the steps you need to take if you disagree with your Medicare drug plan.

What if my plan won't cover a drug I think I need?

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 following two options:

1. You can request a coverage determination if the drug is on your plan's formulary, but your plan won't cover it because it believes that you don't need the drug. You can ask for a coverage determination before paying for the prescription. You can also pay for the prescription, save your receipt, and ask the plan to pay you back by requesting a coverage determination.
2. You can request a type of coverage determination called an "exception" if:
   - you think your plan should cover a drug that's not on its formulary because the other treatment options on your plan's formulary will not work for you.
   - your plan requires you to get permission (prior authorization) before it covers a drug prescribed for you and you disagree.
   - you think your plan should charge a lower amount for a drug you are taking on the plan's non-preferred drug tier because the other treatment options in your plan's preferred drug tier won't work for you.
   - your plan asks you to try another drug before it covers a drug prescribed for you and you disagree.
   - your plan has a limit on the number of pills or dosage for a drug prescribed for you and you disagree.

Your prescriber must send a supporting statement explaining the medical reason for the exception.

How to Request a Coverage Determination or Exception

You, your doctor or other prescriber, or your representative (see "Tip" on the next page) can request that the plan cover the prescription you need. You may file either a standard request or an expedited (fast) request for your coverage determination or exception. Your request will be expedited if your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting for a standard request. Your request won't be expedited if you have already paid for and received the drug.

Tip: The plan must grant an expedited review if your doctor or other prescriber tells your plan that your life or health may be at risk by waiting for a standard request.

You can write a letter or you can use the "Model Coverage Determination Request" form to ask your plan for a coverage determination or exception. You can get a copy of this form by calling your plan or by visiting www.cms.hhs.gov/MedPrescriptDrugApplGriev/13_Forms.asp. Expedited requests may be filed over the telephone or in writing. Standard requests must be filed in writing, unless the plan accepts requests over the telephone.

How to Request a Coverage Determination or Exception (continued)

Once your plan has received the request, it has 72 hours (for a standard request for coverage) or 24 hours (for an expedited request for coverage) to notify you of its decision.

Tip: Any person you appoint, such as a family member, may help you request a coverage determination or file an appeal with your plan. Call your plan to learn how to appoint a representative.

What if I Disagree with the Coverage Determination?

If your Medicare drug plan makes an unfavorable coverage determination decision, it will send you a written decision. If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal.

Tip: When you join a Medicare drug plan, the plan will send you information about the plan's appeal procedures. Read the information carefully and keep it where you can find it when you need it. Call your plan if you have questions.

How to Appeal

There are **five** levels of appeals available to you. **You must follow the order listed below.**

1. Appeal through your plan

The first level of appeal is called a "redetermination." The plan's initial denial notice will explain how to file this appeal. You must request this appeal within 60 calendar days from the date on the coverage determination notice.

You, your doctor or other prescriber, or your representative may request a standard or expedited redetermination. Standard requests must be made in writing, unless your plan allows you to file a standard request by telephone. Your request will be expedited if your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting for a standard decision. Your plan's address and phone number is in your plan materials and will also be in any unfavorable coverage determination decision you get.

Once your plan gets your request for an appeal, the plan has 7 calendar days (for a standard request for coverage) or 72 hours (for an expedited request for coverage) to notify you of its decision.

How to Appeal (continued)

A written request to appeal must include the following:

- Your name, address, and the Medicare claim number (your Medicare number) shown on your Medicare card
- The name of the prescription drug you want your plan to cover
- Reasons why you are appealing
- Your signature or the signature of your representative

You should send any supporting documentation that you believe may help your case, including medical records, with your appeal request.

2. Review by an Independent Review Entity (called a "reconsideration")

If your Medicare drug plan makes an unfavorable redetermination decision, it will send you a written decision. If you disagree with the plan's redetermination, you can request a review by an Independent Review Entity (IRE).

Tip: If your plan issues an unfavorable redetermination, it should also send you a "Request for Reconsideration" form that you can use to ask for a reconsideration. If you don't get this form, call your plan and ask for it. You can also get this form by visiting www.cms.hhs.gov/MedPrescriptDrugApplGriev/13_Forms.asp.

You or your representative must make a standard or expedited request in writing within 60 calendar days from the date of the plan's redetermination decision. Your request must be sent to the IRE at the address or fax number listed in the plan's redetermination decision. This decision letter will be mailed to you. Your reconsideration request will be expedited if the IRE determines, or your prescriber tells the IRE, that your life or health may be at risk by waiting for a standard decision.

Once the request for review has been filed, the IRE has 7 days (for a standard request for coverage or for a request to pay you back) or 72 hours (for expedited requests for coverage) to notify you of its decision.

How to Appeal (continued)

3. Hearing with an Administrative Law Judge

You will receive a written decision from the IRE. If you disagree with the IRE's decision, you or your representative can request an Administrative Law Judge (ALJ) hearing. You must make the request in writing within 60 calendar days from the date on the IRE's decision letter. You must send your request to the location listed in the IRE's decision letter. To get an ALJ hearing, the dollar value of your denied coverage must be at least a certain amount (you may be able to combine claims to meet this dollar amount). The IRE's decision will include the amount.

The ALJ hearing will be conducted by telephone or by video-teleconference. You may also request an in-person hearing. At the ALJ hearing, you will have the chance to explain why your Medicare drug plan should cover your drug or pay you back. You may also ask your doctor or other prescriber to join the hearing and explain why he or she believes the drug should be covered.

4. Review by the Medicare Appeals Council

You will receive a written decision from the ALJ. If you disagree with the ALJ's decision, you or your representative can request a review by the Medicare Appeals Council (MAC). You must make the request to the MAC in writing within 60 calendar days from the date on the ALJ's decision letter. Send your request to the location listed in the ALJ's decision letter.

5. Review by a Federal court

You will receive a written decision from the MAC. If you disagree with the MAC's decision, you or your representative can request a review by a Federal court. You must make the request in writing within 60 calendar days from the date of the MAC's decision notice. You should check with the clerk's office of the Federal court for instructions about how to file the appeal. The court location will be listed in the MAC's decision notice. To get a review by a Federal court, the dollar value of your denied coverage must be at least a certain amount (you may be able to combine claims to meet this dollar amount). The MAC's decision will include the amount.

What can I do if I have a complaint about my plan?

You have the right to file a complaint with the plan. This is sometimes called a "grievance." Some examples of why you might file a complaint include the following:

- The plan doesn't give you a decision about a coverage determination or first level appeal within the required timeframe.
- The plan didn't make a timely decision on your coverage determination request or first-level appeal and didn't send your case to the Independent Review Entity (IRE).
- You disagree with the plan's decision not to grant your request for an expedited coverage determination or first-level appeal (called a "redetermination").
- You have to wait too long for your prescription.
- You believe your plan's customer service hours of operation should be different.
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to the drug plan.
- The plan didn't provide the required notices.
- The plan's notices don't follow Medicare rules.

If you want to file a complaint, you should know the following:

- You must file your complaint within 60 calendar days from the date of the event that led to the complaint.
- You may file your complaint with the plan over the telephone or in writing.
- You must be notified of the decision generally no later than 30 days after the plan gets the complaint.
- If the complaint relates to a plan's refusal to expedite a coverage determination or redetermination and you haven't yet purchased or received the drug, the plan must notify you of its decision no later than 24 hours after it gets the complaint.
- If you think you were charged too much for a prescription, call the company offering your plan to get the most up-to-date price.

If the plan doesn't take care of your complaint, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For More Information

- Visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf to view the booklet "Your Medicare Rights and Protections." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Contact your State Health Insurance Assistance Program (SHIP) if you need help filing an appeal. To get their telephone number, visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites." Or, call 1-800-MEDICARE.

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My Health.
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