Section 5: How do I Appeal if I have Medicare Prescription Drug Coverage?

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If you have Medicare prescription drug coverage through a Medicare Prescription Drug Plan, a Medicare Advantage Plan with prescription drug coverage (MA-PD), or other Medicare plan, your plan will send you information that explains your rights (called an "Evidence of Coverage"). Call your plan if you have questions about your "Evidence of Coverage."

You have the right to request an appeal to resolve differences with your plan. You have the right to ask your plan to provide or pay for a drug you think should be covered, provided, or continued.

Words in red are defined on pages 51–54.

If you decide to appeal, ask your doctor or health care provider for any information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

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 should have to pay, you have the following options:

1. Talk to your prescriber.

Ask your prescriber if you meet prior authorization or step therapy requirements. For more information on these requirements, visit www.medicare.gov/Publications to view or print the fact sheet "How Medicare Prescription Drug Plans and Medicare Advantage Plans with Prescription Drug Coverage (MA-PDs) Use Pharmacies, Formularies, and Common Coverage Rules," or call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should call 1-877-486-2048. You can also ask your prescriber if there are generic, over-the-counter or less expensive brand name drugs that could work just as well as the ones you're taking now.

2. Request a coverage determination (including an "exception").

You, your representative, your doctor, or other prescriber can request (orally or in writing) that your plan cover the prescription you need. You can request a coverage determination if your pharmacist or plan tells you one of the following:

- A drug you believe should be covered isn't covered.
- A drug is covered at a higher cost than you think you should have to pay.
- You have to meet a plan coverage rule (such as prior authorization) before you can get the drug you requested.
- It won't cover a drug on the formulary because the plan believes you don't need the drug.

Words in red are defined on pages 51–54.

You, your representative, your doctor, or other prescriber can request a 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 won't work for you.
- Your doctor or other prescriber believes you can't meet one of your plan's coverage rules, such as prior authorization, step therapy, or quantity or dosage limits.
- You think your plan should charge a lower amount for a drug you're 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.

If you request an exception, your doctor or other prescriber will need to give a supporting statement to your plan explaining why you need the drug you're requesting. Check with your plan to find out if the supporting statement is required and if it must be made in writing. The plan's decision-making time period begins once your plan gets the supporting statement.

You can either request a coverage determination before you pay for or get your prescriptions, or you can decide to pay for the prescription, save your receipt, and request that the plan pay you back by requesting a coverage determination.

You can either file a standard request or a fast request for the coverage determination. See timeframes below.

How do I file a standard coverage determination?

You, your representative, your doctor, or other prescriber can request a coverage determination (including an exception) by following the instructions that your plan sends you. Once your plan has gotten your request, it has 72 hours to notify you its decision.

You can call your plan, write them a letter, or send them a completed "Model Coverage Determination Request" form to ask your plan for a coverage determination or exception. This form is available at www.cms.gov/MedPrescriptDrugApplGriev/13_Forms.asp, or call your plan and ask for a copy. Your plan must accept any written request for a coverage determination from you, your doctor, or your other prescriber.

How do I file a fast coverage determination?

You, your representative, your doctor, or other prescriber can call or write your plan to request that a fast decision be made within 24 hours of your request. You will get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that your life or health may be at risk waiting 72 hours for a decision. You won't get a fast decision if you've already paid for and gotten the drug.

You can call your plan, write them a letter, or send them a completed "Model Coverage Determination Request" form to ask your plan for a fast coverage determination or exception. This form is available at www.cms.gov/MedPrescriptDrugApplGriev/13_Forms.asp, or call your plan and ask for a copy.

What if I disagree with the decision?

Your Medicare drug plan will send you a written decision. If you disagree with this decision, you have the right to appeal.

What is the appeals process?

The appeals process has five levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you will be given instructions on how to move to the next level of appeal.

Level 1: Redetermination from your plan

If you disagree with your plan's initial denial, you can request a redetermination.

You must request the redetermination within 60 days from the date of the coverage determination.

How do I request a redetermination?

Follow the directions in the plan's initial denial notice and plan materials to do this. You, your representative, your doctor, or other prescriber can request a standard or fast redetermination. Standard requests must be made in writing, unless your plan allows you to file a standard request by phone. You will get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that your life or health may be at risk by waiting for a standard decision.

Your plan must accept any written request for a redetermination from you, your representative, your doctor, or other prescriber. A written request to appeal should include the following:

- Your name, address, and the Medicare claim number (your Medicare number) shown on your Medicare card.
- The name of the drug you want your plan to cover.
- Reason(s) why you're appealing.
- Your signature. If you've appointed a representative, include the name and signature of your representative. For more information on appointing a representative, see Section 2.

Send your request along with any other information that may help your case, including medical records. Your plan's address and phone number is in your plan materials and will also be in any written plan decision you get.

Your plan will respond in a "Redetermination Notice" within the timeframes below:

- Standard redetermination decision—7 days
- Fast redetermination decision—72 hours

If you disagree with the plan's redetermination decision in level 1, you have 60 days from the date of the decision to request a reconsideration by an Independent Review Entity (IRE).

Level 2: Reconsideration by an Independent Review Entity (IRE)

If your Medicare drug plan decides against you in level 1, it will send you a written decision. If you disagree with the plan's redetermination, you can request a standard or fast reconsideration by an IRE.

How do I request a reconsideration?

To request a reconsideration by an IRE, follow the directions in the plan's "Redetermination Notice." 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 a copy. This form is also available at www.cms.gov/MedPrescriptDrugApplGriev/13_Forms.asp.

Important: If you want your doctor, other prescriber, or another person to request a reconsideration from the IRE for you, you will need to submit an "Appointment of Representative" form or other documentation to show that the person has the authority to act on your behalf. For more information on appointing a representative, see Section 2.

Send your request to the IRE at the address or fax number listed in the plan's redetermination decision letter that's mailed to you. You will get a fast reconsideration decision 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 IRE gets the request for review, it will send you its decision in a "Reconsideration Notice" within the timeframes below:

- Standard reconsideration decision—7 days
- Fast reconsideration decision—72 hours

If you disagree with the IRE's decision in level 2, you have 60 days from the date of the IRE's decision to request an Administrative Law Judge (ALJ) hearing.

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your appeal to a new person who will independently review the facts of your appeal and listen to your testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-tele-conference, or in some cases, in person. You can also ask the ALJ to make a decision without a 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 can also ask your doctor or other prescriber to join the hearing and explain why he or she believes the drug should be covered.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2011, the required amount is $130. The "Reconsideration Notice" will include a statement that tells you if your case meets this minimum dollar amount. However, it's up to the ALJ to make the final decision. You may be able to combine claims to meet the minimum dollar amount.

How do I request a hearing?

Follow the directions on the IRE's reconsideration notice to request a hearing before an ALJ. Your request must be sent to the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. The address of the appropriate field office is listed in the reconsideration notice. You or your representative can file a request in one of the following ways:

1. Fill out a "Request for Hearing by an Administrative Law Judge" form (CMS Form Number 20034 A/B) available at www.cms.gov/cmsforms/downloads/cms20034ab.pdf, or call 1-800-MEDICARE and ask for a free copy.
2. Submit a letter to the OMHA office that will handle your ALJ hearing. Your letter must include the following:
   - Your name, address, phone number, Medicare number, and the name of your Medicare Prescription Drug Plan. If you've appointed a representative, include the name and address of your representative.
   - The appeal case number included on the reconsideration notice.
   - The prescription drug in dispute. See your redetermination or reconsideration notice for this information.
   - An explanation of why you disagree with the reconsideration decision.
   - Any other information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you will submit it.
   - If you're requesting a fast decision, include a statement that indicates this.
3. If you're requesting a fast hearing, you can make an oral request. Follow the instructions in the IRE's decision notice to do this. The ALJ will give you a fast decision if your doctor or other prescriber indicates, or the ALJ determines, that your life or health may be at risk waiting 90 days for a decision. You won't get a fast decision if you already got the drug.

Words in red are defined on pages 51–54.

Once the ALJ gets the request for review, you will get a decision within the timeframes below:

- Standard ALJ decision—90 days
- Fast ALJ decision—10 days

To learn more about the ALJ hearing process, visit www.hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Medicare Appeals Council (MAC).

Level 4: Review by the Medicare Appeals Council (MAC)

You can request that the MAC review your case. You can request a review for a claim of any amount of money.

How do I request a review?

To request that the MAC review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. Your request must be sent to the MAC at the address listed in the ALJ's hearing decision. You or your representative can file a request for MAC review in one of the following ways:

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101) available at www.hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE and ask for a free copy.
2. Submit a letter to the MAC that includes the following:
   - Your name, address, phone number, Medicare number, and the name of your Medicare Prescription Drug Plan. If you've appointed a representative, include the name and address of your representative.
   - The prescription drug in dispute. See your IRE reconsideration notice or your ALJ hearing decision for this information.

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— A statement identifying the parts of ALJ's decision with which you disagree and an explanation of why you disagree.

— The ALJ appeal case number.

— If you're requesting a fast decision, include a statement that indicates this.

— Your signature. If you've appointed a representative, include the signature of your representative.

3. If you're requesting a fast review, you can make an oral request. Follow the instructions in the ALJ's decision notice to do this. The MAC will give you a fast decision if your doctor or other prescriber indicates, or the MAC determines, that your life or health may be at risk waiting 90 days for a decision. You won't get a fast decision if you already got the drug.

Once the MAC gets the request for review, you will get a decision within the timeframes below:

- Standard MAC decision—90 days
- Fast MAC decision—10 days

To learn more about the MAC review process, visit www.hhs.gov/dab and select "Medicare Appeals Council." If you need help filing a request for MAC review, call 1-800-MEDICARE.

If you disagree with the MAC's decision in level 4, you have 60 days after you get the MAC's decision to request judicial review by a Federal district court.

Level 5: Judicial review by a Federal district court

If you disagree with the decision issued by the MAC, you can request judicial review in Federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2011, the minimum dollar amount is $1,300. You may be able to combine claims to meet this dollar amount.

How do I request a review?

Follow the directions in the MAC's decision letter to file you got in level 4 in order to a complaint in Federal district court. You should check with the clerk's office of the Federal district court for instructions about how to file the appeal. The court location will be listed in the MAC's decision notice.

For more information on the appeals process:

- Visit www.medicare.gov/appeals.
- Call 1-800-MEDICARE.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling. To get the phone number for the SHIP in your state, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

How do I file a grievance or complaint?

If you have a concern or a problem with your plan that isn't a request for coverage or reimbursement for a drug, you have the right to file a complaint (also called a "grievance"). You must file your complaint within 60 days of the date of the event that led to the issue.

Some examples of why you might file a complaint include the following:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to the drug plan.

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- The plan didn't make a timely decision about a coverage determination in level 1 and didn't send your case to the IRE.
- You disagree with the plan's decision not to grant your request for a fast coverage determination or first-level appeal (called a "redetermination").
- 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 days from the date of the event that led to the complaint.
- You can file your complaint with the plan over the phone 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 make a fast 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.

For more information on filing a complaint:

- Visit www.medicare.gov/appeals.
- Call your SHIP for free personalized counseling and help filing a complaint. To get the phone number of the SHIP in your state, call 1-800-MEDICARE or visit www.medicare.gov/contacts.