

FACT SHEET: Medicare Part D Appeals and Grievances

What are my rights if I want to challenge a denial under Part D?

It depends on what kind of action you want to challenge. If your Part D Prescription Drug Plan failed to provide you with a drug you need, then you can ask for a coverage determination, which will trigger your right to formal appeal procedures by independent decision makers.

If you are dissatisfied with an action by your Part D Plan that does not involve drug coverage, you can file a grievance, but you do not have the right to appeal to an independent decision-maker.

If you have been denied a low-income subsidy to help pay the costs of Medicare Part D, your appeal rights will be governed either by the Social Security program or by New York's Medicaid program, depending upon whether you enrolled through Medicaid or through Social Security.

What is a coverage determination?

A coverage determination is a formal determination by a Part D Plan that it will not provide or pay for a covered Part D drug. If your pharmacist tells you that your prescription cannot be filled because the drug is not on your Plan's formulary, or because you have to try a cheaper drug first, that is not a coverage determination. You will have to contact your Plan following the refusal from the pharmacy and request coverage for the drug in order to trigger a coverage determination from your Plan.

A request for coverage is also referred to as a request for an exception, or simply an exception, because providing the drug requires an exception to the Part D Plan's formulary or one of its other cost management tools (such as step therapy, dosage restrictions, therapeutic substitutions, or co-pay tiers).

What is the burden of proof in an exception or coverage request?

To get a drug that is not on a Plan's formulary, or is being dropped from the formulary, a physician must assert that all formulary drugs on any and all tiers would not be as effective as the non-formulary drug. Plans can respond with their own medical or scientific evidence disputing the effectiveness or safety of the non-formulary drug.

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To request an exception from cost management tools such as step therapy or therapeutic substitutions, a physician must assert that the Plan's preferred drugs are less effective or would have adverse effects.

How are exception or coverage requests made?

When a pharmacy tells you that your Plan won't cover a prescribed drug, you or your physician or your appointed representative will need to make a request for coverage or an exception in order to trigger a written coverage determination from the Plan. The pharmacist should provide you with your Plan's phone number following the initial denial at the pharmacy.

Each Plan will have its own exceptions process. It's a good idea to make yourself familiar with this process after you choose a plan.

How much time does the Plan get to respond to my request?

Part D Plans must issue written coverage determinations as expeditiously as an enrollee's health requires, but no later than 72 hours for a standard request, and 24 hours for an expedited or emergency request.

Expedited requests must be made by a physician who states that the 72-hour timeframe would jeopardize the life or health of the enrollee or his or her ability to regain maximum function. You can request a decision even before 24 hours when the situation is an emergency.

Part D Plans do not have to provide you with a temporary supply of drug while your request is pending, unless you are in a nursing home. You cannot get expedited review if you pay for the drug while requesting an exception.

What if I get a negative coverage determination?

If you get a negative coverage determination, you then have 60 days to make a written request for a redetermination by your Plan. The Plan has seven calendar days for a standard redetermination and 72 hours for an expedited redetermination, which must be requested by a physician. The Plan does not have to provide a temporary supply of the drug while your redetermination request is pending.

If the redetermination is also negative, you have 60 days to make a written request for reconsideration by an independent review entity or IRE. If your plan does not make any determination by the applicable time period, the appeal will automatically "escalate" to the IRE. The IRE has seven calendar days to make a standard reconsideration decision and 72 hours for an expedited reconsideration. The IRE must seek input from your prescribing doctor.

Do I have the right to a hearing with an Administrative Law Judge?

If you get a negative decision from the IRE, and the value of one year's worth of your drug(s) is more than \$100, you can request a hearing with an ALJ. You have 60 days to

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make this request and the ALJ must issue a decision within 90 days of receiving the request.

The hearing you will get is a Medicare hearing, not a Medicaid hearing. One important difference is that while you have the right to aid continuing when a service is discontinued or reduced under Medicaid, there will not be any aid continuing while Medicare hearings are pending. Also, under the new process for all Medicare ALJ hearings, your hearing will likely be conducted by video-telephone with an ALJ in Ohio.

If you get a negative decision from the ALJ, you then have 60 days to request a decision from the Medicare Appeals Council. The Medicare Appeals Council has 90 days to issue a decision on your appeal after receiving your request.

If you get a negative decision from the Medicare Appeals Council and one year's supply of your drug(s) is worth \$1050 or more (in 2005), you can file an appeal in federal court. You have 60 days to file the appeal.

It will take a minimum of 28 weeks and up to a year to pursue an appeal under Part D, not including the federal court action. It will take anywhere from six months to two years to get a decision on the federal court action.

How is a grievance different?

A grievance expresses dissatisfaction with a Plan's operations or behavior, other than which drugs it will provide.

Grievances are resolved within the Plan itself and do not carry appeal rights to an independent decision-maker. You have 60 days from the event or incident to file a grievance, and the Plan must make its decision within 30 days.

One exception to the 30-day timeline would be if you decided to file a grievance because your Plan refused to expedite a coverage determination. Part D Plans must make decisions on grievances involving refusals to expedite coverage determinations (and redeterminations) within 24 hours.

What about denials of eligibility for the low income subsidy or "extra-help?"

Disputes regarding eligibility for the low-income subsidy (LIS), also known as "extra-help," do carry appeal rights. The procedures you will need to follow depend on which agency made the adverse eligibility determination.

If a Medicaid office made the adverse LIS eligibility determination, you have the right to notice and a fair hearing with an Administrative Law Judge in the state Office of Temporary and Disability Assistance, just as you do under New York's Medicaid program.

If SSA made the negative LIS determination, you have the right to a telephone hearing with a Subsidy Determination Reviewer in Social Security's Office of Disability and

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Income Security Programs. If you waive the telephone hearing, your appeal will be decided by a case review.

If the negative determination results in reduction or termination of an existing subsidy, both systems allow you to continue to receive the subsidy while your hearing is pending, as long as you request your hearing within 10 days of receiving the adverse determination.

Medicaid fair hearings must be conducted within 90 days of the adverse determination. SSA's administrative review must be conducted within 60 days of the adverse determination. Both systems allow you to file a court action if you wish to challenge the decision after the administrative hearing.

As of the date of this writing, New York State has indicated that it is not yet prepared to make determinations on the Part D low-income subsidies. The State Department of Health is directing local Medicaid offices to send people to the Social Security Administration (SSA) for LIS determinations.

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