



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

Beginning January 1, 2006, Medicare offers insurance coverage for prescription drugs through Medicare drug plans. There are two types of Medicare plans that provide insurance coverage for prescription drugs. There will be prescription drug coverage that is a part of Medicare Advantage Plans and other Medicare Health Plans. There will also be Medicare prescription drug coverage that adds coverage to the Original Medicare Plan and some other Medicare Health Plans.

Medicare drug plans will cover generic and brand-name drugs. Plans may have rules about what drugs are covered in different drug categories. This makes sure people with different medical conditions can get the treatment they need.

Most plans will have a formulary, which is a list of drugs covered by the plan. This list must always meet Medicare's requirements, but it can change when plans get new information. Your plan must let you know at least 60 days before a drug you use is removed from the list or if the costs are changing.



What if I have a complaint about my plan?

If you have a complaint about your Medicare drug plan that doesn't involve coverage or payment for a drug covered by the Medicare drug plan, you have the right to file a complaint with the plan (called a "grievance"). You should file your complaint within 60 days of the event that led to your complaint. 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 pharmacy is charging you more than you think you should have to pay.*
 - The company offering your plan is sending you materials not related to the drug plan that you didn't ask to get.
 - 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 decision and send your case to the independent review entity (IRE) about a coverage determination or first-level appeal within the required timeframe.
 - You disagree with the plan's decision not to grant your request for an expedited coverage determination or first-level appeal.
 - The plan didn't provide the required notices.
 - The plan's notices don't follow Medicare rules.
- * 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.



What if my plan won't cover a drug 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 right to

- request a decision called a “coverage determination” from your plan, or
- pay for the prescription and request that the plan pay you back by requesting a coverage determination, or
- request a coverage determination if your plan requires you to try another drug before it pays for the drug prescribed for you, or there is a limit on the quantity or dose of the drug prescribed for you and you disagree with the limit.

You, your doctor, or your appointed representative can call your plan or write them a letter to request that the plan cover the prescription you need.

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

Once your plan has received the request, it has 72 hours (for a standard request for coverage or for a request to pay you back) or 24 hours (for an expedited request for coverage) to notify you of its decision. Your request will be expedited if your plan determines or your doctor tells your plan that your life or health will be seriously jeopardized by waiting for a standard decision.

Note: For some types of coverage determinations (called “exceptions”), you will need a supporting statement from your doctor explaining why you need the drug you are requesting. You may need this statement if you are requesting that the plan cover a drug that isn't on its list of covered drugs (formulary) or you want the plan to cover a non-preferred drug at the preferred drug cost. Check with your plan to find out if the supporting statement is required. Once your plan receives the statement, its decision-making time period begins.



How to Appeal

If the plan decides against you, you can appeal the decision. There are **five levels** of appeal available to you.

1. Appeal through your plan (called a “redetermination”). You must request this appeal within 60 calendar days from the date of the coverage determination. You or your appointed representative must file a standard request, in writing, unless your plan accepts requests by telephone. You, your appointed representative, or your doctor can call your plan or write to them for an expedited request. Your request will be expedited if your plan determines or your doctor tells your plan that your life or health will be seriously jeopardized by waiting for a standard decision.

Your plan’s address is in your plan materials. Once your plan receives your request for an appeal, the plan has seven days (for a standard request for coverage or for a request to pay you back) or 72 hours (for an expedited request for coverage) to notify you of its decision.

2. Review by an independent review entity (called a “reconsideration”). If the plan again decides against you, you can request a review by an independent review entity (IRE). You or your appointed representative must make a standard or expedited request within 60 days from the date of the decision. The request must be made, in writing, to the IRE. Your request will be expedited if the IRE determines or your doctor tells the IRE that your life or health will be seriously jeopardized by waiting for a standard decision.

Once the request for review has been filed, the IRE has seven 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. If the IRE agrees with your plan's decision, you or your appointed representative can request a hearing with an administrative law judge (ALJ). You must make the request in writing within 60 days from the date of the notice of the IRE decision. You must send your 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 dollar amount). The IRE's decision will include this amount. Once the request for an ALJ hearing is received, the ALJ generally has 90 days to make a decision.

4. Review by the Medicare Appeals Council. If the ALJ agrees with your plan's decision, you or your appointed representative can request a review by the Medicare Appeals Council (MAC). You must make the request to the MAC, in writing, 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 for a review.

5. Review by a Federal court. If the MAC agrees with your plan's decision, you or your appointed representative can request a review by a Federal court. You must make the request, in writing, within 60 days from 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 review by a Federal court, the projected value of your denied coverage must meet a minimum dollar amount. The MAC's decision will include the amount.

Note: 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 can I learn more

- Look at the “Medicare & You 2006” handbook, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) for detailed Medicare drug plan information. TTY users should call 1-877-486-2048.
- Read new Medicare publications that can help you compare drug plans and enroll, such as the tip sheet “Comparing Medicare Prescription Drug Coverage” (CMS Pub No. 11110) and the fact sheet, “New Medicare Prescription Drug Coverage—Who Can Help Me Apply and Enroll?” (CMS Pub No. 11125). You can get copies by calling 1-800-MEDICARE or visiting www.medicare.gov on the web.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized counseling (check the back cover of your “Medicare & You 2006” handbook for the telephone number in your state).
- Attend Medicare-related events in your community. Look for information about these events in your local newspaper or listen for information on the radio.



Notes

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