



Getting Medicare right

Date: _____

Dear Helpline Caller:

The Medicare Rights Center is a national, nonprofit organization. We help older adults and people with disabilities with their Medicare problems. We support caregivers and train professionals. We also teach people about Medicare and advocate for policy reform. The Medicare Rights Center is not part of Medicare. We aren't connected to any insurance company or plan.

You recently called our helpline for help with a denial you got from your Medicare Part D drug plan. By law, you have the right to appeal this denial. Appealing is how you can ask the plan to cover your drug.

Enclosed is information to help guide you through the Part D appeals process.

If you have more questions or concerns, please call us again at 800-333-4114.

Sincerely,

Helpline Counselor



What to do when your Part D plan won't pay for a drug you need

If your Medicare Part D drug plan won't pay for a drug you need, you don't have to take no for an answer. You can appeal.

Appealing means formally asking the plan to cover your drug. Common reasons for appealing are:

- The drug you need isn't on your plan's list of covered drugs (**formulary**).
- Your drug plan only covers a limited amount of the drug you need (**quantity limits**).
- Your plan wants you to try other drugs first (**step therapy**).
- You must get special permission from the plan in advance before it will cover your drug (**prior authorization**).
- Your plan is charging more for your drug than for similar drugs on its formulary.

There are certain steps you should follow when you appeal. These steps are the same for all Part D plans. Both you and your plan have time frames within which to complete each step.

Most people don't have to go through all these steps to get their drug. However, it's helpful to know the steps and how they work.

These are the steps for any Part D appeal:

Step 1: Request an exception.

- Before you can start your appeal, you must formally ask your plan to cover the drug you need. This is called **requesting an exception**. You're asking the plan to make an exception to its normal rules and cover your drug.
- When you request an exception, you must send a letter to your plan from your doctor. The letter should say why you need the drug and that drugs on the formulary won't work as well for you or will harm you. This is called a **letter of medical necessity**.
- You can request an exception to cover a drug that isn't on the plan's formulary. Or you can request an exception to waive restrictions your plan has put on your drug. Restrictions are special coverage rules. Common restrictions are **prior authorization** (requiring the plan's permission in advance), **step therapy** (requiring you to try cheaper drugs) and **quantity limits** (limits on the amount or dose of the drug).
- You can ask the plan to lower the copay for your drug. The copay is what you pay at

the pharmacy. You can ask the plan to charge you less if there's a similar drug on a lower copay tier (a preferred drug) that won't work as well for you or will harm you.

- You can ask the plan to cover the drug indefinitely. That way, if you win your appeal the plan will cover the drug as long as you're in the plan. Otherwise, the plan usually only covers the drug until the end of the calendar year.
- You or your doctor should send a copy of the doctor's letter (letter of medical necessity) and any medical records that support your request. For example, you may want to send medical histories or lab reports.

Step 2: Appeal if your plan denies your exception request.

- If your plan won't grant an exception, you can appeal. This step is called getting a **redetermination**. To do so, you can send many of the same materials from Step 1 to your plan's Appeals Department.
- You should send a doctor's letter again. It should answer the reason the plan gave for denying coverage. This may require updating the original letter. For example, if the plan tells you to try other drugs on the formulary, the letter should say why those other drugs won't work for you. Or if the plan says it will only cover a certain amount of a drug, your doctor should write why you need the prescribed dosage. (See Sample Letter of Medical Necessity).
- You should again include medical records to support the appeal.
- Send receipts if you paid out-of-pocket for your drug. Ask the plan to reimburse you.

Step 3: Get an independent review.

- If your plan denies your appeal and says it still won't cover your drug, the next step is to send your appeal to the **Independent Review Entity (IRE)**. You can also do this if the plan doesn't respond on time.
- Send all your documents (including receipts) to the IRE. The IRE is a company called **Maximus Federal Services**. Maximus works for the federal government to review appeals. It isn't associated with any private Part D drug plan.
- Include your Medicare number, your birth date and contact information.

Step 4: If Maximus denies your appeal, you can appeal to the next level.

There are several more levels of appeal. Most people don't have to do this.



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Tips on Appealing

- Submit your requests in writing. Keep proof of when you sent your appeal. Keep all fax transmission reports or mail information by certified mail or return receipt. Write down details about phone calls regarding your appeal. This includes what you discussed, who you spoke to, and the date and time of the call.
- If your health is in danger, your doctor can ask the plan for a fast decision. This is called an expedited appeal.
- Meet the deadlines. Demand that your plan do the same. You and your plan have a certain amount of time at each level of appeal.
- If you think you need help appealing, you can appoint a representative. The representative can be a friend, family member, doctor or lawyer.
- During the appeals process, you might pay out-of-pocket to get the drug your plan is denying. If you do this and later win your appeal, the plan must reimburse you. Submit receipts to your plan with your appeal.

Part D Appeals Process

Request an Exception

Ask the plan to cover your drug and remove coverage restrictions. Your doctor's supporting letter is key to your success. Call the plan to find out where to submit the request.

Standard Request

Plan must answer in 72 clock hours.

Expedited (urgent) Request

Plan must answer in 24 clock hours.

Appeal

If the request is denied, send your appeal to the plan's **Grievance & Appeals** Department within **60 days** from date on denial notice. Contact information will be on the notice.

Standard Appeal

Plan must answer in 7 calendar days.

Expedited Appeal

Plan must answer in 72 clock hours.

Get an Independent Review

Send your appeal to Maximus within **60 days** from the date on the denial notice.
Maximus Federal Services
3750 Monroe Ave., Suite 703, Pittsford, NY 14534
Tel. 877-456-5302, Fax 866-825-9507

Standard Independent Review by Maximus

Maximus must answer in 7 calendar days.

Expedited Independent Review by Maximus

Maximus must answer in 72 clock hours.

More Levels of Appeal

If Maximus denies your appeal, the next step is to go to the Office of Medicare Hearings and Appeals (OMHA). Include an Appointment of Representative form if a doctor is appealing for you. After that, you can get a Council hearing and judicial review.



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Part D Appeals Tips for Doctors

Your patient may not be able to get the drug you prescribed if their Part D plan doesn't cover it. Or the plan may have put restrictions on the drug that keep your patient from getting it (such as prior authorization, step therapy or quantity limits).

If this is the only drug that works for your patient, your help is key to getting coverage. **For the appeal to be successful, you—as the prescribing doctor—must explain the medical necessity of the prescription that's being denied.** You must affirm that ONLY the prescribed medication works for your patient. You should write a letter of medical necessity. The letter should say why the patient needs the drug and that drugs on the formulary won't work or could be harmful to that patient.

Your letter of medical necessity is needed before the appeals process begins, when you or the patient **requests an exception**. This is when you ask the Part D plan to say in writing whether it will cover the drug or waive restrictions. The plan must make a written **coverage determination**.

If the coverage determination is favorable, the patient can get the drug. If not, the patient can start the appeals process (ask for a **redetermination**). A letter of medical necessity from you should be submitted when asking for a redetermination and at further levels of appeal if the plan continues to deny coverage.

You can use your original letter at each step in the appeals process. But the patient has a better chance of winning if you revise the letter to specifically address the reason for each denial.

The appeals process is the same whether you're asking for the plan to cover an off-formulary drug or asking the plan to remove restrictions. Your help is crucial to getting coverage.

It's important to check your patient's Part D plan formulary. There may be another drug on the formulary that will work for your patient and doesn't have restrictions on it. If you can prescribe that drug for your patient, you can avoid the appeals process.

If only the prescribed drug will work, appealing with a letter of medical necessity is the only way to get the plan to cover the drug.

More Tips for Doctors on Submitting Requests

- Submit all requests to the plan in writing.
- Keep proof of when you submit requests to the plan. These include fax transmission reports or certified mail return receipts. If you do this, the plan can't delay the appeals process by saying it never got the request.
- You may need to have your patients appoint you as their representative by filling out an appointment of representative form if you appeal on their behalf during upper levels of the appeals process.
- Doctors can now directly appeal on behalf of their patients from the Exception Request level through the Independent Review Entity (IRE) level. Doctors appealing on behalf of their patients **do not** need to fill out an Appointment of Representative form to appeal for their patients during this part of the appeal process. If you are appealing on behalf of your patients for the Office of Medicare Hearings and Appeals (OMHA) level or above, you will still need to submit a signed Appointment of Representative form.
- You can resubmit the same letter of medical necessity at each level of appeal. But it's best to address the reason for the denial. For example, the plan might deny the drug because the patient hasn't tried alternatives on the formulary. In that case, it's important to write in the letter that the patient tried the suggested alternatives and they didn't work. Or indicate that the patient can't try the alternatives because they would be ineffective or harmful.



Doctor's Sample Letter of Medical Necessity

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Print on your office letterhead.

Should accompany any required plan exception request forms.

Date:
Name of patient:
Plan/Member ID:
Medicare #:
Date of birth:

[Name of patient] has been under my care for **[number of years]**. **[His/Her]** diagnoses are **[diagnoses]**. In order to appropriately treat **[name of patient]**'s medical condition, I have prescribed **[name of medication, dosage, and amount]**.

[Name of medication] at **[dosage]** is medically necessary for **[name of patient]** because **[reasons]**. If **[s/he]** cannot take this medication, **[consequences of not taking the medication at issue]**.

[USE THE FOLLOWING PARAGRAPHS AS APPLICABLE]

No other **[medications/dosages]** in this class and category on the **[name of plan's]** formulary have been or would be as effective in treating **[name of patient]** because **[reasons]**. **[List any other medications/dosages prescribed to treat your patient's condition that were less effective than the drug/dosage at issue, and/or that you believe would be less effective for your patient.]**

Alternative **[medications/dosages]** in this class and category **[have caused or could cause name of patient]** to experience serious adverse consequences. **[List any other medications/dosages your patient has tried to treat the condition that had serious adverse consequences, and/or other drugs/dosages your patient has not tried that might be prescribed to treat the condition, but which you believe pose too much risk for your patient, and why.]**

[USE IF REQUESTING EXPEDITED EXCEPTION]

In my professional opinion, **[name of patient]** must receive an expedited decision in order to obtain **[name of medication at dosage]** immediately. Failure to get this medication quickly will seriously jeopardize **[name of patient's]** life or health or ability to regain maximum function because **[reasons]**.

Please contact me should you require any additional information. I can be reached at **[number]**.

Sincerely,
[Doctor's signature]
[Doctor's full name]