



The Medicare Counselor

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Medicare Rights Center

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Do you need help

understanding your Medicare benefits?

Call the Medicare Rights Center's national hotline at 800-333-4114.

Counselors are available Monday through Friday, from 9 a.m. to 5 p.m. ET for accurate, up-to-date information and ongoing support.

Part D Excluded Drugs: Knowing What Is and Is Not Covered

What drugs are covered by [Medicare prescription drug coverage \(Part D\)](#) often depends on which drugs your Part D plan chooses to include on its specific list of covered drugs or "[formulary](#)." However, [some drugs are explicitly excluded](#) from Medicare coverage by law. These include:

- Drugs for:
 - Anorexia, weight loss or weight gain (except to treat physical wasting caused by AIDS, cancer or other diseases)
 - Fertility
 - Cosmetic purposes or hair growth
 - Relief of the symptoms of colds, like a cough and stuffy nose
 - Erectile dysfunction
- Prescription vitamins and minerals (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs (over-the-counter drugs)
- Certain anti-anxiety drugs (barbiturates and benzodiazepines)

Prescription drugs used for the above conditions will **not** be covered by Medicare Part D. However, they may be covered if they are being prescribed to treat **other** conditions. For example, prescription medications for the relief of cold symptoms may be covered by Part D if prescribed to treat something other than a cold—such as shortness of breath from severe asthma—as long as they are approved by the U.S. Food and Drug Administration (FDA) for such treatment, or the treatment appears in the Medicare-approved drug compendia.

The above excluded classes of drugs include prescription drugs like the commonly-prescribed Xanax, Valium and Ativan. But, while these drugs will never be paid for by Medicare, Part D plans—which are run by private companies paid by Medicare to administer benefits to you—can still choose to cover them as an added benefit to you.

So, if you need one of these drugs, you may be able to find a plan in your area that **does** cover it. However, although these excluded drugs may be on your plan's formulary, [what you pay](#) and what your plan pays for them will not contribute to the amount of money you must spend before [catastrophic coverage](#) begins.

If a drug that **could** be covered by Medicare is not listed on your drug plan's formulary, you can [request an exception](#). However, if your Part D plan does **not** cover a drug from the excluded classes mentioned above, **you cannot request an exception for your plan to cover an excluded drug**. (Note: If your doctor prescribes a drug that turns out to be excluded, you do technically have the right to appeal when you receive the denial from the plan. However, such appeals are rarely granted.)

There are a number of avenues you can take to get help paying for excluded drugs. They include asking your doctor for samples of medications (a short-term solution), and/or enrolling in a private, state or nationally run assistance program.

Medicaid

If you have Medicaid and Medicare, your state Medicaid program may cover some excluded drugs. In many states, [Medicaid wraps around the Medicare drug benefit](#) to cover some drugs that are excluded from Medicare coverage by law. State Medicaid programs vary as to what they cover. Medicaid will never cover drugs to treat erectile dysfunction.

For an overview of the Medicaid/Part D wrap in each state, view the Medicare Rights Center's chart, "Medicaid Coordination with Part D (By State)"

(www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/mi_extra/medicaid_variables.html).

Call your local Medicaid office for more information.

Quick Tip: FDA-Approved Drug Uses

If your doctor prescribes a medication on the formulary for a reason **other than** the use approved by the U.S. Food and Drug Administration—an "off-label" use—your drug will probably not be covered unless the use is listed in one of three Medicare-approved drug compendia (medical encyclopedias of drug uses). You can ask for an exception, but these requests are rarely granted.

The only exception to this standard is for **anticancer chemotherapeutic regimens**, for which Medicare began accepting indications of drug use from additional compendia and other peer-review literature in January 2009.

You may also receive a denial from your Part D plan stating that your drug does not meet "DESI standards." The FDA's Drug Efficacy Study Implementation (DESI) evaluates the effectiveness of those drugs that had been previously approved on safety grounds alone. Drugs that are found to be "less than effective" by DESI evaluation are excluded from coverage by Part D.

State Pharmaceutical Assistance Programs

Your [State Pharmaceutical Assistance Program](#), or SPAP for short, may also be another option. States can choose to offer stand-alone coverage or fill in the gaps in Medicare drug coverage (Part D) for individuals enrolled in the state's drug assistance program. Each state decides how its program will coordinate with Medicare drug plans. Some SPAPs may cover drugs excluded by Medicare.

View the Medicare Rights Center's chart, "State Pharmaceutical Assistance Programs (SPAPs)" (www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/mi_extra/spap_chart.html) to find out if your state has an SPAP and how it works with Part D.

Prescription Drug Discount Programs

Additionally, you may be able to get financial assistance through prescription drug discount programs. These programs may be able to get you reduced prices on excluded Part D drugs from national and local discount programs.

View the Medicare Rights Center's charts on "National Prescription Drug Discount Programs"

(www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/mi_extra/discount_chart_national.html) and "State-Sponsored Prescription Drug Discount Programs

(www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/mi_extra/discount_chart_state.html) for more information.

Patient Assistance Programs (PAPs)

You may be able to get free or low-cost drugs directly from the company that makes them. Many companies have their own programs. In most cases, your doctor must apply for you. While many patient assistance programs do not allow you to apply if you are eligible for the Medicare drug benefit (Part D), some do.

See the Medicare Rights Center's lists of National and State resources that can help you find Patient Assistance Programs:

(www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/mi_extra/pap_chart_national.html) and www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/mi_extra/pap_chart_state.html).

State Health Insurance Assistance Program (SHIP) and local Area Agency on Aging

If you still need help paying for your Part D excluded medications you can contact your [State Health Insurance Assistance Program \(SHIP\)](#) or local [Area Agency on Aging](#). They may be able to direct you to more resources in your area. Find contact information for your SHIP at www.shiptalk.org.



Are you a caregiver in need of information?

Check out the Medicare Rights Center's FREE educational web seminar "Medicare Information for Caregivers" to learn more about how Medicare works and what resources are available to you.

Register online starting Monday, June 1 at: www.medicarerights.org/medicare-answers/courses-training.php



Want more information on the topics in this issue?

Visit the Medicare Rights Center's FREE online Medicare counseling and information tool, Medicare Interactive (MI) Counselor! Visit MI Counselor today at MedicareInteractive.org!

The Part D Appeals Process

If you get your drug coverage from a [Medicare private drug plan \(Part D\)](#), there may be times when a drug that can be legally covered by Part D (not [excluded from Medicare drug coverage](#)) is not easily accessible through your plan. For instance:

- It may not be on your plan's [formulary](#) (the list of prescription drugs for which your plan will help pay); or
- It may be on your plan's formulary, but with [restrictions](#):
 - **Prior-authorization** (You must ask your plan's permission before it will pay for the drug);
 - **Step therapy** (Your doctor must show that you tried a less expensive medication before your plan will cover a more expensive one); and
 - **Quantity limits** (Your plan will only cover a certain amount—like number of pills—of a drug each month).

In these cases, you will have to [file an “exception” request](#) to ask your drug plan to cover the drugs that you need. You may also need to file for an exception if:

- **Your medication is in a higher copayment “tier” than similar drugs on the formulary.** If you are prescribed a “non-preferred,” more expensive drug because your doctor thinks it is the only medication on the formulary that will work for you (there is no good generic or “preferred” alternative), you can ask your plan to move your medication to a lower cost tier. Drugs on lower tiers of a formulary cost less.

However, you **cannot** request that your plan move the drug to a lower tier if

- the drug you need is in a “specialty tier” (often the most expensive drugs); **or** you want to access a brand-name drug at the same copayment tier as a generic drug.

To file an exception, [follow these steps](#):

Step 1: Request an exception to the plan's formulary.

Being told at the pharmacy that your drug will not be covered by your plan is not an official denial. For that, you need to **request a formal exception** from the plan. To request an exception, you must include a letter of medical necessity from your doctor explaining that no other drug will work for you. You or your doctor should send a copy of your doctor's letter and any medical records that support



*Medicare
Part D
Appeals
Help for
Advocates*

The Medicare Rights Center's *Medicare Part D Appeals: An Advocate's Manual to Navigating the Medicare Private Drug Plan Appeals Process* offers an easy-to-understand, comprehensive overview of the entire appeals process, including real-life case examples.

Get a FREE copy of this great resource:

www.medicarerights.org/pa_rtd_appeals_manual.pdf

your request, such as medical histories or lab reports, to your plan. To find out where to send the exception request, call your plan or look at its website, or check in your plan's "Evidence of Coverage" booklet.

- You can request an exception to cover the drug or waive restrictions your plan has placed on your medication (such as prior authorization, step therapy or quantity/dosage limits).
- You can ask the plan to approve the drug indefinitely, so that it will be covered as long as you are a member of the plan. Otherwise, the plan will generally cover the medication (or waive restrictions) until the end of the calendar year.

Step 2: If your plan denies your request for an exception, [appeal!](#)

If your exception request is denied, your plan should send you a written denial titled "**Notice of Denial of Medicare Prescription Drug Coverage.**" The notice should clearly explain why the plan is denying coverage for your prescription and tell you where to send your appeal. You have 60 days from the date on the "Notice of Denial" to submit your appeal. (Under certain circumstances, you may be able to appeal after 60 days if you have "good cause"—for example, if you were in the hospital and therefore could not appeal earlier.) By appealing, you are asking for a **redetermination** from the plan.

- Send the same materials from Step 1 to your plan's Appeals Department.
- Your doctor's letter should address the reason given for the denial. This may require updating the original letter. For example, your doctor should confirm that other medications on your plan's formulary have not worked for you or why you require the prescribed dosage of the drug. See "Sample Letter of Medical Necessity"

(www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/tips_physician_appeals.pdf) for an example of what your doctor's letter should look like.

- If you have to pay for your drug out of pocket since your plan denied your exception request, be sure to submit receipts and request reimbursement from your plan in your appeal.

The plan must respond no later than seven calendar days from the date it received the request. If it is an emergency, you or your doctor can ask for an "**expedited redetermination.**" Your plan must respond to an expedited appeal within 72 clock hours (**not** work hours).

Step 3: Get an independent review from the Independent Review Entity.

If your plan denies coverage again **or** does not respond within the required timeframe, get an independent review from the Independent Review Entity (IRE), Maximus Federal Services, the private contractor that handles Medicare prescription drug appeals when your plan has denied your request for coverage. Maximus is not affiliated with any Medicare private drug plan, and will therefore make an independent decision about your case—one that is based solely on your medical need for a particular drug and/or dosage of that drug, **not** on the cost of your prescription or who is paying for it.

Appealing to Maximus is no more difficult or complicated than appealing to your plan. Appeal within 60 days of the date on the second "Notice of Denial" from your Medicare private drug plan. Send all your documents—including any receipts for out-of-pocket expenses for the denied prescription—to the Independent Review Entity. Include your 10-digit Medicare number, date of birth and contact information on the appeal.

- If your plan raised new reasons for denying coverage for your prescription in its second denial notice, your doctor may want to update their letter of medical necessity to address those new reasons. Maximus must return a decision within seven days for standard appeals and 72 hours for expedited appeals.
- If your doctor submits this appeal on your behalf, you will need to appoint your doctor as your representative by signing an “**Appointment of Representative**” form. Have your physician submit the form along with the letter of medical necessity. A signed “Appointment of Representative” form allows your doctor to represent you throughout the appeals process. A signed form also allows your doctor to represent you in any other Medicare prescription drug appeals over the course of the calendar year.

Higher Levels: ALJ, MAC and Judicial Reviews

If you disagree with Maximus’s decision, you can request an ALJ hearing within 60 days of Maximus’s decision if the amount in question meets the minimum amount that Medicare sets each year (\$120 in 2009). Multiple appeals can be consolidated to meet this amount, allowing you to project the cost of the drug to include all refills you will need for the calendar year.

If you disagree with the ALJ’s decision, you can appeal within 65 days of the date on the ALJ decision to the MAC. The MAC can also review the ALJ decision on its own initiative.

If you disagree with the MAC’s decision or if the MAC denied the request for appeal, and the amount in question meets the minimum amount that is adjusted annually (\$1,220 in 2009), you can request review by a federal court.

If the IRE, ALJ, MAC or federal court

decides the plan must cover the drug you need, the plan must process the coverage within 72 hours (24 hours for an expedited appeal) from the date the plan receives the decision. If the case involves a reimbursement request, the plan must authorize reimbursement within 72 hours and pay within 30 calendar days from the date it receives the decision. If your plan does not process the coverage or issue reimbursement within these timeframes, file a complaint with your plan and notify Maximus Federal Services.

Tips for the Appeals Process

- Submit your requests in writing. Keep proof, such as fax transmission reports, certified return mail receipts or phone logs, of when you submitted your request. Write down the name of plan representatives with whom you speak.
- If your health is in danger, your doctor can request an “expedited”—or fast—decision.
- Meet the deadlines—and demand that your plan do the same.
- If your doctor appeals on your behalf at upper levels, you may have to appoint him/her as your representative. Use the “Appointment of Representative” (“Rep”) form.
- You are entitled to reimbursement for out-of-pocket expenses incurred while your appeal is in process. Submit your receipts to your plan with your appeal and request reimbursement for any costs paid out of pocket
 - If you did not submit receipts with your appeal, you are still entitled to reimbursement. To request reimbursement after you win your appeal, submit copies of receipts of

your medication (or print-out from the pharmacy), a copy of your approval notice, and plan's claim form (this is optional; plans cannot require these forms, but many do). Your plan is required to approve payment within 72 hours and send you a check within 30 days.

- For help with your appeal, call the Medicare Rights Center at 888-466-9050.
- It is very unlikely that you will win an appeal for a drug that is specifically excluded from Medicare coverage by law. For more information on drugs that are excluded from Medicare coverage, see the article on "[Part D Excluded Drugs](#)" on page 1.

Medicare Coverage of Oxygen Equipment

In the past few years, there have been some changes to rules concerning the rental of oxygen equipment. The following clarifies the **current** rules.

If you need oxygen equipment, Medicare will only pay for you to rent it; it will not pay for you to buy it. The rental period lasts for up to five years (as long as you still require the equipment).

1. **During the first 36 months (3 years),** Medicare will pay a monthly rental fee to the supplier. If you have [Original Medicare](#), Medicare pays 80 percent of the rental amount, and [you are responsible](#) for any unpaid Part B deductible, and the remaining 20 percent of the rental amount (plus additional costs if your supplier does not accept assignment). If you have a [Medicare Advantage](#) plan, you may have a [copayment](#) that is set by your plan. The monthly rental payments to the supplier covers not only your oxygen equipment, but also any supplies and accessories such as tubing or a mouthpiece, oxygen contents, maintenance, servicing and repairs.
2. **After the 36 month period ends,** Medicare will stop paying monthly rental fees to the supplier and you will no longer have to pay a monthly rental coinsurance for the oxygen equipment. The supplier must allow you to keep the same equipment for up to two more years (as long as you still need it during that time). During this time, your

supplier must keep the equipment in good working condition and provide you supplies, parts and maintenance free of charge **in most cases**.

Although you will no longer pay a monthly rental coinsurance, **you may be charged a fee in the following instances after the 36-month rental period:**

- **If you use oxygen tanks or cylinders,** you will be charged coinsurance or copayments for liquid or gaseous oxygen that the supplier delivers to you on a monthly basis plus additional costs if your supplier does not accept Medicare's approved payment for a service ("assignment") as payment in full.
- **During 2009, if you use an oxygen concentrator or transfilling equipment** (a machine that fills your portable tanks in your home), your supplier can bill you for one general in-home maintenance visit. You will be responsible for a 20 percent coinsurance (plus additional costs if your supplier does not accept Medicare's assignment as payment in full).

At the end of the five-year period, a new rental period will begin and you will have to get new oxygen equipment if you still need it. You can choose whether to get it from the same supplier you got your previous equipment from or switch to a new supplier.

There are [three types of durable medical equipment \(DME\) suppliers](#) under Original Medicare. The one you choose affects how much your costs will be.

1. **To save the most**, choose suppliers who are **enrolled and “participating” in Medicare**. They must bill Medicare and **take assignment**—accept the Medicare-approved amount as payment in full. You or your supplemental insurance will pay 20 percent of that amount (plus any unmet portion of your Part B deductible).

The supplier can ask you to pay this amount up front (although they must still submit the bill to Medicare), but it’s best to find one who will not. If you do pay up front, save your receipt and make sure that you have paid the correct amount when you receive your [Medicare Summary Notice \(MSN\)](#) for the service. If you have paid more than 20 percent of Medicare’s approved amount, seek reimbursement from the supplier for the extra amount.

2. Suppliers who are **enrolled but “not participating” in Medicare** are not required to accept assignment as payment in full. **They are not limited in how much they can charge you and can ask for payment up front**, although they must still submit the bill to Medicare. Medicare will then reimburse you for 80 percent of its approved amount (minus any unmet portion of your Part B deductible), and **you pay the balance** (balance billing). Medigap plans that cover excess charges do not cover overcharges from DME suppliers.

- Non-participating suppliers can choose to take Medicare assignment on a case-by-case basis. It is worth asking the supplier to take assignment for your equipment.

3. **You may have to pay the full cost yourself** if you choose a supplier who is **not enrolled in Medicare**. These non-

enrolled suppliers are not limited in how much they can charge you and can ask for payment up front.

Such suppliers are required to notify you in advance—in writing with an [“Advance Beneficiary Notice”](#)—that they are not enrolled in Medicare and, therefore, you will be responsible for the full cost of the equipment. If they fail to do this—and so there was no way you could know you were responsible for the full cost—Medicare will determine that you cannot be charged for the equipment. You should submit the claim to Medicare. Medicare should then tell the supplier that it must reimburse you for any money you paid. You will not be responsible for any fees, and the supplier must generally refund you any money you paid.

To save money, **it is best to go to a Medicare-enrolled supplier who accepts Medicare’s assignment**. To find a Medicare-enrolled supplier near you, call 800-MEDICARE or check the Medicare Supplier Directory on Medicare’s website at www.medicare.gov/Supplier/Home.asp.

All Medicare-enrolled DME suppliers are required to bill Medicare on your behalf (without any charge to you for doing so). If a Medicare-enrolled supplier refuses to bill Medicare, contact your local durable medical equipment administrator, the DME MAC in your area, to report Medicare fraud by calling 800-MEDICARE.

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