



CMA Weekly Alert – January 19, 2006

## **THE PART D PERFECT STORM: WHAT TO DO IF YOU CAN'T GET MEDICATIONS YOU NEED FROM YOUR MEDICARE PRESCRIPTION DRUG PLAN**

### **Introduction**

The media, and advocates for people with Medicare, are focusing on the problems of dual eligibles who cannot get access to medically necessary drugs because drug plans are not honoring their obligation to provide a transition supply of prescribed medications. Despite statements by the Centers for Medicare & Medicaid Services (CMS), these issues will not go away even as drug plans get their computer and customer service systems up and running. As more people enroll and use their drug plans, problems will persist. They may change, but they will not go away.

Medicare's "Transition" policy only requires a drug plan to fill a prescription for a non-formulary drug or for a drug that requires prior authorization or other plan approval *one time* when the person first enrolls in a drug plan. After receiving the transitional *first-fill*, the beneficiary is expected to either go through the process to get the drug paid for by the plan or get a prescription for a different drug that is on the plan's formulary from the treating physician. Unfortunately, advocates report that many people are leaving pharmacies without their medications. Even when beneficiaries are able to secure a transitional supply of medications, they are not being told that they must take further action to get their medications next month.

As a result, in February, we can expect people to be told once again by their pharmacy that their Part D plan will not pay for their medications. But next month, the plans will not be required to supply the medications, and most states will not fill in the gaps.

This *Weekly Alert* is designed to provide Medicare beneficiaries with information about the steps they need to take when they are told their drug plan will not pay for their medications.

### **What to Do When Your Drug Plan Won't Pay for Your Medicine**

***ANY TIME you can't get your prescription filled, for ANY reason, you (or someone you authorize to act for you) must contact your Part D Prescription Drug Plan and ask for an official "coverage determination" to explain why you can't get your prescription filled. You need this official explanation before you can take steps to get the drug you need, and it will tell you what to do next.***

## **What happens at the drug store?**

When your drug plan does not cover your medicine, your pharmacy should either give you a piece of paper telling you to contact your drug plan or have a sign posted that explains how to get more information. Even if your pharmacy tells you why the drug isn't covered, you still must contact your drug plan.

Your drug insurance card will have the drug plan's phone number. If you don't have a drug card, look in the *Medicare & You Handbook* you received in October or call 1-800-Medicare. (NOTE: Some plan phone numbers were listed incorrectly in the *Medicare & You Handbook*.)

## **How long do I have to call my drug plan?**

You have up to 60 days to contact the drug plan for an explanation as to why it will not cover your medicine, but the longer you wait, the longer it may take for you to get your prescription. You can also send a written request to the drug plan. There is no special form to use, but you should say you want a "Coverage Determination" when making your request. (Some Coverage Determinations are called "Exceptions". See below for details.)

## **What happens when I call my drug plan?**

Ask why coverage has been denied for your medication and state that you want a *written explanation*. The drug plan must issue a written "Coverage Determination" that gives the reasons for the plan's denial of payment for your prescription, and tells you what you need to do next to challenge the drug plan's decision. If at all possible, get a letter from your doctor explaining why you need the medication. Submit it to the plan and keep a copy for your records.

The drug plan must issue the written Coverage Determination, within 72 hours of your request. It may have to issue the decision within 24 hours if you ask for, and are granted, "expedited" review. If an expedited decision is important, get a statement from your physician explaining that this is necessary, and why. The plan may have to issue the decision even sooner if your health condition requires a more immediate answer. If you have already paid for the drug yourself, the plan will issue a decision in 72 hours. If the drug plan doesn't issue a decision in time, it is required to send your claim to an outside, independent reviewer.

## **What can I do if the drug plan denies my request to pay for the drug?**

You have 60 days to ask the plan for a "Redetermination" of its original decision. Your drug plan may require you to make a request for a "redetermination" in writing. The unfavorable coverage determination will tell you how to request a redetermination.

If you request a Redetermination, your drug plan must issue a written decision within 7 days or within 72 hours if you are entitled to expedited review. The drug plan may have to make a decision more quickly if your health condition requires a more immediate answer. The plan will issue a decision in 7 days if you have already paid for your drug. If the drug plan doesn't issue a decision in time, it is required to send your claim to an outside, independent reviewer.

The written decision will explain the reasons for the drug plan's decision and tell you what to do next.

## **What happens if the drug plan continues to say it won't pay for the drug?**

You have 60 days to file a written request for reconsideration with the Independent Review Entity (IRE). The request must be in writing; there is no option to call the IRE to request a redetermination.

The IRE is an independent company that contracts with Medicare to review prescription drug claims. Maximus is currently the company that has been hired by Medicare to perform this job.

The IRE will review the evidence and may contact you or your doctor. It will then issue a written decision that tells you the reasons for the decision and what you need to do next. The decision should be issued within 7 days or within 72 hours if you are entitled to expedited review.

## **What happens if the IRE denies my claim?**

If the value of your claim is large enough, you may request a hearing before an Administrative Law Judge (ALJ). The hearing process for denied drug claims is the same as the process for appeals from denied hospital, nursing home, doctor, and other Medicare claims.

In 2006, your claim must be at least \$110 to get an ALJ hearing. This amount may change each year. In determining this amount, Medicare will consider the cost of your drug over the course of the year. For example, if your drug costs \$30, and you have 4 refills left, the value of your claim will be \$120.

## **Can I appeal if the ALJ denies my claims?**

Yes. You can ask for review by the Medicare Appeals Council (MAC) and even by federal court if the claim is large enough. Your claim must be worth \$1090 to file an appeal in federal court in 2006. The written decision from the ALJ and then from the MAC will tell you how to proceed.

## **Involving Your Doctor in Your Appeal**

*Your prescribing doctor plays a critical role if your drug claim is denied. In some cases, you cannot get the drug plan to pay for your drug without your doctor's help.*

## **When is help from my doctor required?**

You must have a doctor's statement when you are requesting a *special type of Coverage Determination called an "Exception."* A plan will not grant your Exception request without a statement from your doctor.

## **When would I ask for an *Exception*?**

You would ask for an Exception:

- When the drug you need is not on your drug plan's list of covered drugs (formulary),
- When your drug plan requires you to get its approval (prior authorization) before it will pay for your drug,
- When the drug plan wants you to try a less expensive drug before paying for the prescribed drug (step therapy or fail first),

- When the drug plan limits the number of pills you may have (quantity limits), or
- To reduce the co-payment you have to pay to a lower, less expensive tier of co-payments.

### **How do I ask for an Exception?**

You ask for an Exception the same way you would ask for any Coverage Determination. It is important to note that *your doctor can ask for an Exception for you*. Some drug plans may require your doctor to use a special form when asking for prior authorization or making a different exceptions request. Each drug plan may have its own form or forms.

Even if the plan allows the doctor to request an Exception by telephone, the doctor should follow the telephone request with a written statement.

### **What does the doctor's statement have to say?**

Each drug plan sets its own requirements for the doctor's statement. You or your doctor should check with the Evidence of Coverage from your drug plan, or directly with the plan itself, to find out its requirements. At a minimum, the doctor's statement would have to show that you need to take the prescribed drug because taking any of the similar drugs on the plan's formulary would cause adverse health consequences, would not be as effective, or both.

### **What happens if the exception request is denied?**

As described above, you can ask your drug plan for a redetermination, just as you would if you got any other unfavorable coverage determination. The rest of the appeals process is also the same as that described above.

### **Are there other times when I should seek help from my doctor?**

*A drug plan and the Independent Review Entity must grant a request to expedite a coverage determination (including an Exception), a Redetermination, or a Reconsideration if a doctor asks for expedited review.* They do not have to grant such a request if you make it yourself.

You should ask your doctor to request expedited consideration when making an Exceptions request. The doctor should indicate that waiting for a decision during the standard time period could seriously jeopardize your health or life or your ability to regain maximum function.

### **Conclusion**

CMS has stated publicly that Medicare beneficiaries will have access to a wide array of drugs, though they may have to use the exceptions and appeals processes to get some of them. Only time will tell whether beneficiaries and doctors find these processes easier to use than the transition and other processes CMS said would help all beneficiaries get their medicine when the new Part D drug benefit went into effect.

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