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WHAT TO DO WHEN YOUR DRUG PLAN WON'T PAY FOR YOUR MEDICINE

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“It’s ridiculous that Medicare beneficiaries are being denied drugs they need, that they have taken for years in some cases,” states Judith Stein, Executive Director of the Center for Medicare Advocacy. “There *are* some things people can do to help themselves when, as is happening so often, they are denied Medicare drug coverage. But, unfortunately, many just aren’t aware that they have recourse.” Beneficiaries whose prescriptions are denied should remember the following:

- *Any time* you can’t get your prescription filled, for *any* reason, you (or someone you authorize to act for you) have 60 days to contact your Part D Prescription Drug Plan and ask for an official “coverage determination” to explain why you can’t get your prescription filled. *Even if your pharmacy tells you why the drug isn’t covered, you still must contact your drug plan for this written explanation.*
- State that you want a written explanation. The drug plan must issue a written “Coverage Determination” explaining the reasons for denial, and what you can do next.
- Your doctor is your most important resource. Get a letter from your doctor explaining why you need the medication. Submit it to the plan and *keep a copy* for your records.
- If you are denied again, you have 60 days to request a “Redetermination” which will explain the reasons for the drug plan’s decision and tell you what to do next
- If you are denied a third time, you have 60 days to request a “Reconsideration” with the “Independent Review Entity”, a company separate from your drug plan (Maximus is the name of the current Independent Review Entity). They will contact you or your doctor, and will issue a written decision explaining the reasons for the drug plan’s decision and telling you what to do next
- If you are denied by the Independent Review Entity, and your claim has a value of \$110 (for 2006) you may request a hearing before an Administrative Law Judge. In determining the amount, Medicare *will* consider the cost of your drug over the course of the entire year.

“It’s also likely,” continues Ms. Stein, “that people are unaware that there is a process by which they can request an ‘Exception’ from certain plan rules and get coverage for their medications.” *These requests will not be granted without a doctor’s statement* explaining the need for the prescribed medication. Exceptions should be requested when:

- The drug you need is not on your drug plan’s list of covered drugs (formulary),
- Your drug plan requires you to get its approval (“prior authorization”) before it will pay for your drug,

- The drug plan wants you to try a less expensive drug before paying for the prescribed drug (“step therapy” or “fail first”),
- The drug plan limits the number of pills you may have (quantity limits), or
- You wish to reduce the co-payment you have to pay to a lower, less expensive tier of co-payments.

Ask for an Exception the same way you would ask for any Coverage Determination. *Your doctor can ask for an Exception for you.* Do everything in writing and keep copies, even if other options are allowed.

“Denials, glitches, and problems with part D may never end,” concludes Ms. Stein, “but knowledgeable consumers can make it easier on themselves. And, of course, if they still have questions, there are organizations like the Center for Medicare Advocacy willing to help them with this process.”