



The Medicare Prescription Drug Benefit Program (Part D): How to Appeal a Denial of Coverage

WHAT CAN I DO IF I FIND OUT THAT A MEDICATION I NEED IS NOT COVERED BY MY MEDICARE PRESCRIPTION DRUG PLAN?

1. If the pharmacist tells you a drug is not covered by your Part D plan, he or she should give you a notice titled “Medicare Prescription Drug Coverage and Your Rights Notice.” Call your plan and find out the reason it is not covering your drug.
2. If the drug is either too expensive because it’s non-preferred or is not covered at all because it is not on the plan’s formulary,¹ you may first file an Exception Request with your Part D plan. You can make either a standard or expedited request. Exception Requests are granted when a plan determines that a requested drug is medically necessary for the Part D enrollee. Exception Requests **MUST** be submitted with a supporting statement from the prescribing physician. Exception Request determinations are made, after the plan receives the prescribing physician’s supporting statement, within 72 hours for standard requests, or within 24 hours for expedited requests. Expedited requests are for when a person’s life, health or ability to regain maximum function is in jeopardy.
3. For drugs not covered for other reasons, a Coverage Determination can be requested by you, your representative or by the prescribing physician. You can request a Standard or Expedited determination by filing a request with the plan, either orally or in writing. The plan must provide notice of its decision within 72 hours for a Standard request, or within 24 hours for an Expedited request. Similar to Exception Requests, expedited requests are for when a person’s life, health or ability to regain maximum function is in jeopardy.
4. Certain Coverage Determination requests **MUST** be accompanied by a statement supporting your request from the prescribing physician. These requests include exceptions to the drug plan’s formulary (i.e., a drug is not covered, a drug is no longer covered, there’s a requirement to try a different drug first, quantity limits), waiver of prior authorization requests, and requests a drug be moved to a different tier (e.g., to lower the copayment).
5. Because the plans must make a determination within 24 to 72 hours, the initial determination may be provided orally. However, the plan will mail you a written decision as well. If your plan decides to cover your drug at any step in the appeals process, it must be covered at least until the end of the current calendar year.

WHAT HAPPENS IF I AM DENIED AN EXCEPTION?

If the decision for an Exception Request or Coverage Determination is unfavorable, you have the right to appeal the decision through the Part D appeals process. There are several levels in the appeals process:

¹ A formulary is an approved list of drugs covered by the prescription drug plan.

1. You have the right to a redetermination by your Medicare drug plan. The plan's notice of denial will include directions on how to file an appeal.
 - Your request must be made within 60 days of receiving notice of your plan's denial decision. Please note that some plans may accept oral requests. You should seek your doctor's support when filing this request.
 - You have the right to request an exception to the 60-day rule upon showing of good cause, for example, sickness, death or illness of family member, incorrect information from the plan and destroyed records.
 - The plan must issue a determination no later than seven (7) calendar days from the date it receives your request.
 - You have the right to ask for an expedited redetermination. You must submit an oral or written request directly to the plan. You can also ask your doctor to make the request.
 - The plan must respond to an expedited request no later than 72 hours after receiving your request.
2. If the plan denies your redetermination request, you have the right to appeal to the Independent Review Entity (IRE) within 60 days of the date of the plan's redetermination denial.
 - The IRE is an independent agency that contracts with Medicare to handle these appeals and is not affiliated with any Medicare private drug plan. Note that some IREs refer to themselves as "Part D QICs."
 - The IRE must respond as expeditiously as your health condition requires. It must not exceed the deadline specified in their contract, 7 days for standard requests and 72 hours for expedited requests.
3. If your request is denied by the IRE, you have the right to an Administrative Law Judge (ALJ) hearing.
 - You have the right to request an ALJ hearing within 60 days of the IRE decision if the cost of the drug is \$150 in 2016 and \$160 in 2017.
 - You have the right to request an exception to the 60-day rule upon showing of good cause, for example, sickness, death or illness of family member, incorrect information from the plan and destroyed records.
 - You may be able to combine multiple appeals to meet the minimum dollar amount – you can calculate the cost of the drug to include all of the refills that you will need for the calendar year. The ALJ will decide if your case meets the minimum dollar amount.
 - The IRE or QIC notice of denial will include instructions on how to file an ALJ hearing appeal.
 - Generally, the ALJ will issue a written decision within 90 days.
4. If the ALJ hearing is not successful, you may appeal the decision to the Medicare Appeals Council (MAC). The MAC reviews ALJ decisions. The ALJ's decision will include instructions on how to request an MAC review.
 - You may file a written request along with documents or evidence within 60 days from the date of the ALJ hearing decision. This timeframe may be extended upon a showing of good cause.
 - The MAC has the right to deny or dismiss your request.
 - If the MAC grants your request, it can issue a decision or remand the case to an ALJ.
 - Generally, the MAC should issue a decision within 90 days.

5. Finally, if your appeal to the MAC was unfavorable, you have the right to Judicial Review.
- If you disagree with the MAC's decision or if the MAC denied your request for an appeal, you have the right to file an appeal in Federal District Court within 60 days of the date on your MAC denial notice.
 - Your case must meet the minimum amount of drug costs - \$1500 in 2016 and \$1560 in 2017.

WHERE CAN I GET HELP WITH FILING AN APPEAL?

You can find more information about exception requests and the various levels of appeals by contacting Medicare at 1-800-MEDICARE. If you are interested in filing an appeal, you can also contact MFY Legal Services.

WHO CAN I CONTACT IF I HAVE QUESTIONS?

You may call MFY Legal Services, Inc.'s Government Benefits Project at 212-417-3732 on Mondays from 10:00 a.m. to 12:00 p.m. If you are a mental health consumer you may call MFY's Mental Health Law Project at 212-417-3830 on Mondays, Tuesdays, and Thursdays from 10:00 a.m. to 5:00 p.m.

DISCLAIMER: This fact sheet gives general information for NYC residents; it is NOT legal advice.