

MEDICARE DRUG PLANS WHAT DO I DO WHEN I CAN'T GET THE MEDICATIONS I NEED?

**By the Minnesota Disability Law Center
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Are you enrolled in Medicare Part D, and you cannot get the medications you need? You **can** challenge a decision your drug Plan makes. This fact sheet tells you when you have a right to fight a denial by your Drug Plan, and how to do it.

NOTE: YOUR PHARMACY *DOES NOT* MAKE DECISIONS ABOUT YOUR MEDICATIONS. YOU MUST DEAL WITH YOUR DRUG PLAN WHEN A DRUG IS DENIED.

WHAT KINDS OF DECISIONS CAN I CHALLENGE?

There are several reasons you may not be able to get a drug you need. Here are the kinds of Plan decisions that you can challenge.

- Your Plan says the drug is not medically necessary.
- Your Plan says you have to get approval from them before it will pay for the drug you need.
- Your Plan says you have to try other medications, and show they do not work well before they will approve the one you are asking for (“step therapy”).
- Your Plan does not agree with
 - the dosage
 - the manner of medication (for example, liquid or pill)
 - the type (generic versus brand name)
 - the number of refills your doctor is requesting.
- Your Plan only offers the drug to people who pay a different premium level than you do.
- What you pay now is more than what you would pay on a different level of your Plan.
- Your Plan says it does not offer that drug on its formulary (list of drugs), or it used to offer it but now it does not.
- The pharmacy you used is not in your Plan’s network.

DO I NEED HELP FROM MY DOCTOR?

Yes. You have to get help from your doctor if you want to fight a denial of a medication by your drug Plan. You cannot do it alone!!!

- **Your doctor is the one who needs to ask for an “expedited” process.** This means asking to speed up the time your Plan has to make a decision. Your doctor must give them a verbal or written statement. This statement has to say why you need them to decide quickly. Usually it will show that waiting puts your health in danger. If your doctor asks for an “expedited” process, the Plan has to agree.
- **Your doctor has to show why you need a certain drug.** Your doctor needs to give your Plan a verbal or written explanation of why the drug is “medically necessary”, and why other drugs

won't work. For example, you may need an "exception" to the formulary available to you. This means you need something that is not on the list of drugs your Plan offers. Or maybe it is on the list for people paying a higher premium.

- **Your doctor has to show that you need the drugs you are asking for even if they are not on your formulary.** The Plan needs to know that the drugs they offer do not work as well as what you want or may have bad effects. "Step therapy" is when you go through other, cheaper drugs one by one to see if they work for you. If you want to get a drug without having to do this, your doctor will have to explain why it is important for you to skip those steps.
- **If your Plan has a limit on dosage or number of refills, your doctor has to show that you need more than the Plan lets you have.**

HOW DO I CHALLENGE A DECISION MY PLAN MAKES?

If you want a drug that your Plan **does not** offer, you have to ask for an "exception". If you want a drug your Plan **does** offer, but your Plan tells you "no", you can appeal. For both of these there are steps you have to follow called the "exceptions and appeals process". Each step only happens if the one before it did not get you the change you need. The steps are:

- the initial decision or determination,
- the redetermination,
- the independent review process,
- a hearing in front of an Administrative Law Judge
- appeal to the Medicare Appeals Council
- review by the Federal District Court

If your doctor has to do papers for any of these steps, check back to make sure that they have been sent.

Step 1 - Determination: If you cannot get a drug you need you have to ask for a **written coverage determination** from your Plan. This is a letter that tells you why they won't give you that drug. It will also tell you how to challenge the decision.

- You have up to 60 days to ask - but since the drug is important to your health, **don't wait that long**. Remember, they will probably not make any decisions until they get information from your doctor. Talk to your doctor!
- After they hear from your doctor, they have 72 hours to respond.
- Each Plan has different ways of doing a determination. Call your Plan to find out how they do it.

If you can't wait that long to get your medication you need an **expedited** determination.

"Expedited" means your Plan has to make a decision within 24 hours. Your doctor needs to ask for this and explain why you cannot wait. Because the time is short, your Plan can let you and your doctor know verbally about its decision but they have to send you a written decision afterwards.

If your Plan gives you a favorable written coverage decision (meaning they say ok), that decision is good for the Plan year. They may extend it into the next Plan year. You can ask them to do this. If they decide to not give you what you ask for, they have to send you information on how to challenge their decision. If you want to challenge it you have to ask for a **redetermination**.

Step 2 - Redetermination: This is when your Plan reviews its own coverage decisions.

- You have up to 60 days to ask - but since the drug is important to your health, **don't wait that long.** Talk to your doctor so s/he can send them any information they need.
- After they get information from your doctor, they have up to 7 days to respond. They may ask for more information.

If you can't wait that long to get your medication your doctor needs to ask for an **expedited** decision. This gives the Plan 72 hours to make a decision. Your Plan can let you and your doctor know verbally about its decision but they have to send you a written decision within 3 days.

If you get a favorable decision at this stage, the decision is good for the Plan year. If they say no again, you can then ask for an **Independent Review.**

Step 3 - Independent Review Entity: In an independent review the decision is made by an outside organization. This organization is called the Independent Review Entity (IRE). They are hired by the federal government. The IRE decides if you should get the drug you are asking for. Right now the IRE is an organization called Maximus. Your Plan has to tell you how to appeal to Maximus so they can review and make a new decision.

- You have up to 60 days to ask - but since the drug is important to your health, **don't wait that long.** You have to ask in writing! The IRE has to contact your doctor to make sure they have all the information they need.
- The IRE usually has 7 days to review your case and make a written decision.

If you need an expedited determination your doctor needs to ask for it. Then they have 72 hours to make a decision.

The IRE process is not a hearing. It is a review of the Plan's process and the information you and your doctor have given to the Plan. They have to make sure that everything important to the case is in the records - especially why you need that medication. The IRE has to look at all the information and use that to make their decision.

If the IRE decision is in your favor, it is good for the Plan year. Most problems are fixed by this step. But if the decision is against you, the IRE will give you information about how to appeal your case to the next level, the **Administrative Law Judge (ALJ) hearing.** You may want help from a lawyer for the ALJ hearing.

Step 4 - Administrative Law Judge (ALJ) hearing. The ALJ step is a "hearing" with an administrative law judge, who works for Medicare.

To get an ALJ hearing, your case or "claim" must be worth at least \$110 in the year 2006. To figure out the worth of your claim, look at the total cost of the drug, not just your share of the cost. For example, if the drug you are trying to get costs your drug Plan \$25 per refill and your doctor is recommending 6 refills ($\$25 \times 6 = \150), then your claim is worth at least \$110, even if you only pay \$1 per refill. So you can ask for an ALJ hearing.

- You have up to 60 days to ask - but since the drug is important to your health, **don't wait that long.**
- The ALJ has 90 days to accept your request for a hearing. You can show proof and bring witnesses to help your case with the ALJ. There are very few places to have these hearings in person so most ALJ hearings are done by video teleconferences.
- The ALJ has 90 days to decide if you should be able to get the drug you are asking for.

If you lose, the decision from them will explain your next step for appealing to the **Medicare Appeals Council.**

Step 5 - Medicare Appeals Council. You have to appeal to the Medicare Appeals Council (MAC). This step is a paper review of the ALJ hearing and decision. This means they will look at all the papers about your case. You do not have to go anywhere.

- You have 60 days to request a review by the MAC.
- The MAC has 90 days to make a decision.

If they do not agree with you, you may be able to appeal to federal court. The written decision from the MAC will explain how you can appeal to **federal court.**

Step 6 - Federal Court Review. This is your last chance to challenge the decision. You have 60 days from the date of the MAC decision to file in federal court. **It is a good idea to get a lawyer** if you don't have one already. It can be confusing to go to federal court because of court requirements and the rules you have to follow.

To go to federal court, the worth of your claim has to be at least \$1,050 for the year (2006). Count what the drug will cost for the year. Look at the total cost, not just your part of it. If you only have 1 drug on appeal that will cost \$150 for the year, that is not enough to go to federal court.

If you have more than 1 drug on different appeals you can add the costs together. In other words, if you have 1 drug you are trying to get that costs the drug Plan \$600 for the year, and another drug that costs \$500, you can add them together. The total (\$1,100) is enough for a federal court appeal.

WHAT IF I LOSE ALL MY APPEALS?

If you try all these steps but lose, you should talk to your doctor about other medications on your Plan's formulary that may work for you. Some drug manufacturer programs may offer the drug for free or reduced cost.

You can also contact the Linkage Line at 1-800-333-2433; TTY 1-800-627-3529. The Linkage Line may be able to tell you if there are other programs that can help you pay for your drugs.