



Medicare Prescription Drug Coverage: How to File a Complaint, Coverage Determination, or Appeal

Medicare offers insurance coverage for prescription drugs through Medicare drug plans. To get coverage for prescription drugs, you can

- 1) Join a Medicare Prescription Drug Plan that adds drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans, or
- 2) Join a Medicare Advantage Plan (like an HMO or PPO) that includes prescription drug coverage as part of the plan. You get all of your Medicare coverage through these plans, including prescription drugs.

Medicare drug plans cover generic and brand-name drugs. Plans may have rules about what drugs are covered in different drug categories. Check to see if the plan covers your prescription drugs. Medicare drug plans will have a list of drugs (formulary) covered by the plan that must always meet Medicare's requirements. Even if a drug is on the plan's list, there may be special rules for filling the prescription. Also, the list can change during the year because drug therapies change, and new drugs and medical knowledge become available. If there is a formulary change that affects a drug you take, your plan will notify you at least 60 calendar days before the formulary changes. In most cases, the drug will still be covered for you until the end of the year, but you should check with your plan to make sure.

*My Health.
My Medicare.*



What can I do if I have a complaint about my plan?

You have the right to file a complaint with the plan. You must file your complaint within 60 calendar days of the date of the event that led to your complaint. Some examples of why you might file a complaint include the following:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The pharmacy is charging you more than you think you should have to pay.*
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to the drug plan.
- The plan doesn't give you a decision about a coverage determination or first level appeal (see "How to Appeal" number 1) within the required timeframe. (A coverage determination is a decision from your Medicare drug plan about whether a drug you need is covered by the plan and how much you must pay for the prescription.)
- The plan didn't make a decision about a coverage determination or first-level appeal within the required timeframe and didn't send your case to the independent review entity (IRE).
- You disagree with the plan's decision not to grant your request for an expedited coverage determination or first-level appeal.
- The plan didn't provide the required notices.
- The plan's notices don't follow Medicare rules.

* If you think you were charged too much for a prescription, call the company offering your plan to get the most up-to-date price. If the plan doesn't take care of your complaint, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



What if my plan won't cover a drug I need?

If your pharmacist tells you that your Medicare drug plan won't cover a drug you think should be covered, or it will cover the drug at a higher cost than you think you are required to pay, you have the right to

- request a coverage determination from your plan,
- pay for the prescription, save your receipt, and request that the plan pay you back by requesting a coverage determination, or
- request a coverage determination if your plan requires you to try another drug before it pays for the drug prescribed for you, or there is a limit on the quantity or dose of the drug prescribed for you and you disagree with the limit.

You, your doctor, or your appointed representative (see “Tip” below) can call your plan or write them a letter to request that the plan cover the prescription you need.

Tip: Any person you appoint, such as a family member or your doctor, may help you request a coverage determination or an appeal. Call your plan to learn how to appoint a representative.

You may file either a standard request or an expedited request for your coverage decision. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be seriously jeopardized by waiting for a standard request. Once your plan has received the request, it has 72 hours (for a standard request for coverage or for a request to pay you back) or 24 hours (for an expedited request for coverage) to notify you of its decision.

Note: For some types of coverage determinations called exceptions, you will need a supporting statement from your doctor explaining why you need the drug you are requesting. You may need this statement if

- you are requesting that the plan cover a drug that isn't on its list of covered drugs (formulary),
- you want the plan to cover a non-preferred drug at the preferred drug price, or
- your doctor believes that you can't meet one of your plan's coverage rules, such as a prior authorization, quantity limit, or dose limit.

Check with your plan to find out if the supporting statement is required, and if it must be in writing. If a supporting statement is required, the plan's decision-making time period begins once your plan receives the statement.



How to Appeal

If the plan decides against you, you can appeal the decision. There are **five levels** of appeal available to you. **You should follow the order of the steps listed below.**

Note: When you join a Medicare drug plan, the plan will send you information about the plan's appeal procedures. Read the information carefully and keep it where you can find it when you need it. Call your plan if you have questions.

1. Appeal through your plan

The first level of appeal is called a “redetermination.” The plan's initial denial notice will explain how to file this appeal. You must request this appeal within 60 calendar days from the date of the coverage determination. You or your appointed representative must file a written standard request. Some plans will allow you to file a request by telephone. You, your appointed representative, or your doctor can call your plan or write to them for an expedited request. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be seriously jeopardized by waiting for a standard decision. Your plan's address is in your plan materials and will be in any unfavorable coverage determination decision you receive. Once your plan receives your request for an appeal, the plan has seven calendar days (for a standard request for coverage or for a request to pay you back) or 72 hours (for an expedited request for coverage) to notify you of its decision.

2. Review by an independent review entity (called a “reconsideration”)

If the plan again decides against you, you can request a review by an independent review entity (IRE). You or your appointed representative must make a standard or expedited request in writing within 60 calendar days from the date of the plan's redetermination decision. The request must be sent to the IRE. The IRE's address will be in the plan's unfavorable redetermination decision, which will be mailed to you. Your request will be expedited if the IRE determines, or your doctor tells the IRE, that your life or health may be seriously jeopardized by waiting for a standard decision.

Once the request for review has been filed, the IRE has seven days (for a standard request for coverage or for a request to pay you back) or 72 hours (for expedited requests for coverage) to notify you of its decision.



How to Appeal (continued)

3. Hearing with an administrative law judge.

If the IRE agrees with your plan's decision to deny coverage, you or your appointed representative can request a hearing with an administrative law judge (ALJ). You must make the request in writing within 60 calendar days from the date of the notice of the IRE decision. You must send your request to the location specified in the IRE's reconsideration notice. To get an ALJ hearing, the projected value of your denied coverage must meet a minimum dollar amount (you may be able to combine claims to meet the minimum dollar amount). The IRE's decision will include this amount.

4. Review by the Medicare Appeals Council

If the ALJ agrees with your plan's decision to deny coverage, you or your appointed representative can request a review by the Medicare Appeals Council (MAC). You must make the request to the MAC in writing within 60 calendar days from the date of the notice of the ALJ's decision. You must send your request to the location specified in the ALJ's decision notice.

5. Review by a Federal court.

If the MAC agrees with your plan's decision to deny coverage, you or your appointed representative can request a review by a Federal court. You must make the request, in writing, within 60 calendar days from the date of the notice of the MAC's decision. You must send your request to the location specified in the MAC's decision notice. To receive a review by a Federal court, the projected value of your denied coverage must meet a minimum dollar amount. The MAC's decision will include the amount.

How can I learn more?

- Visit www.cms.hhs.gov/MedPrescriptDrugApplGriev on the web for more detailed information about Medicare prescription drug appeals and grievances.
- Look at the "Medicare & You" handbook, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) for detailed Medicare drug plan information. TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized counseling. To get their telephone number, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites." Or, call 1-800-MEDICARE (1-800-633-4227).
- Attend Medicare-related events in your community. Look for information about these events in your local newspaper or listen for information on the radio.