



The Medicare Prescription Drug Benefit Program: How to Appeal a Denial to an Exception by Your Plan

YOU HAVE RIGHTS

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

1. Once you realize that your drug is not covered, contact your plan to request a formulary¹ exception. The plan must respond to your request no later than 14 calendar days after they receive your request. Please note that the plan may extend this timeframe by up to 14 days if they justify a need for additional information. They must inform you of this extension in writing.
2. You have the right to request an expedited determination where the plan must respond within 72 hours. Please note that the plan may notify you in writing that they intend to extend this timeframe by up to 14 days if they justify a need for additional information.
3. To ask for an expedited determination, you must submit an oral or written request directly to the plan. You can also ask your doctor to make the request.

The plan will decide whether expedite your request based on the following:

- If it determines that the standard timeframe for making the determination could seriously jeopardize your life, health, or your ability to regain maximum function.
 - For requests made by your doctor, the plan must expedite the determination if your doctor indicates that the standard timeframe for making the determination could seriously jeopardize your life, health, or your ability to regain maximum function.
4. You have the right to file an expedited grievance if your plan denies the expedited request. The plan must notify you with instructions about this process. It is important that you submit this request with your doctor's support.

WHAT HAPPENS IF I AM DENIED AN EXCEPTION?

If your plan denies an exception to its formulary, you have the right to appeal its decision. There are several levels in the appeals process:

1. You have the right to reconsideration by your Medicare private drug plan. You must do the following:
 - You have the right to file a written request to your plan for a second review within 60 days of receiving notice of your plan's decision. Please note that some plans may accept oral requests. You should seek your doctor's support when filing this request.

¹ A formulary is an approved list of drugs that will be covered by the plan.

- 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 30 calendar days from the date it receives your request.
 - You have the right to ask for an expedited reconsideration. You must submit an oral or written request directly to the plan. You can also ask your doctor to make the request.
 - The plan will decide whether expedite your request based on the following:
 - If it determines that the standard timeframe for making the determination could seriously jeopardize your life, health, or your ability to regain maximum function.
 - For requests made by your doctor, the plan must expedite the determination if your doctor indicates that the standard timeframe for making the determination could seriously jeopardize your life, health, or your ability to regain maximum function.
 - The plan must respond to an expedited request no later than 72 hours after receiving your request.
 - Please note that the plan may notify you in writing that they intend to extend the standard or expedited timeframe by up to 14 days if they justify a need for additional information.
 - If the plan fails to deny your request or fails to act within these timeframes, it must forward the appeal to the Independent Review Entity (IRE) within 24 hours of its determination or the missed deadline.
2. Your reconsideration request may be referred to the Independent Review Entity (IRE). The IRE is an independent agency that contracts with Medicare to handle these appeals and is not affiliated with any Medicare private drug plan.
- Your plan must notify you that your appeal was forwarded to the IRE.
 - The plan must make reasonable and diligent efforts to assist in gathering and forwarding information to the IRE.
 - The IRE must respond as expeditiously as your health conditions requires. It must not exceed the deadline specified in their contract.
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 amount in question meets the minimum amount that Medicare will announce annually (\$100 in 2005)
 - 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 can combine multiple appeals to meet this amount- you can calculate the cost of the drug to include all of the refills that you will need for the calendar year.
4. If the ALJ hearing is not successful, you may appeal the decision to the Medicare Appeals Council (MAC). The MAC is part of the Department of Health and Human Services that reviews ALJ decisions.
- You may file a written request along with documents or evidence within 60 days after your hearing decision. This time frame may be extended upon 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.
 - You may request to appear before the MAC to present oral argument. If this request is granted, the MAC will inform you of the date at least 10 days before the scheduled date.
 - The MAC may also decide to review your case on its own motion.

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 a judicial review in Federal District Court within 60 days after the date you receive your notice from the MAC.
 - This timeframe may be extended by filing a request with the MAC upon showing of good cause.
 - The amount in question must meet the minimum amount that Medicare will announce annually (\$1050 in 2005).

WHERE CAN I GET HELP WITH FILING AN APPEAL?

If you are interested in filing an appeal, you can contact MFY Legal Services at the following numbers:

Adult Home Residents can call (212) 464-8110
Mental Health Consumers can call (212) 417-3830
Elderly living in Manhattan can call (212) 417-3880