

# Appealing Change in Drug Coverage

By Anne Tergeesen , The Wall Street Journal

Every winter, millions of Medicare Part D recipients go to fill a prescription, only to learn that their plan no longer covers the medication.

People in this situation can always switch to a similar drug that's covered, provided their doctor says it's safe and effective. But they also can launch a formal appeal of the denial -- and the odds of success are high.

Such problems often crop up at this time of year because Jan. 1 is when many Part D plans change their list of covered medications.

When a plan decides to drop or restrict its coverage of a drug, it's required to inform participants. But some plans fail to do so in a timely fashion. And some Part D recipients fail to read or understand these notifications, says Paul Precht, director of policy and communications for the nonprofit Medicare Rights Center.

Jan. 1 also is when Part D recipients who have elected to switch plans do so. And some are misinformed by plan representatives as to what is covered, says Mr. Precht.

If your plan won't cover a drug you are taking, you don't have to take no for an answer. Those new to a plan can request a 30-day "transition" supply. The new plan is required to cover that amount -- provided you make the request within 90 days of enrolling, says Dina Wizmur, deputy general counsel at the Medicare Rights Center.

But to ensure continued coverage, you will have to ask the plan to reconsider its decision to deny coverage in the first place.

The first step: Ask your doctor to file a request for "coverage determination." He or she should explain why the medication is medically necessary on the "Medicare Part D Coverage Determination Request Form." Your doctor should have it. If not, ask your insurer. The plan has 72 hours in which to respond. With "expedited" requests, you should hear back within 24 hours.

If you don't prevail, you'll have 60 days to start the formal appeals process. First, file a "re-determination" request, by following the instructions on your denial. The plan has seven calendar days to respond, or 72 hours with an "expedited" request.

If you aren't successful, you'll have 60 days to file another appeal -- this time, to Maximus Federal Services ( [www.medicarepartDappeals.com](http://www.medicarepartDappeals.com)), a company Medicare employs to handle these cases. The turnaround time is seven days or 72 hours.

Provided at least \$130 is at stake, the next step would be to take your case to an administrative law judge. You'll participate in a hearing over the phone or via videoconference. A decision must be rendered within 90 days of the appeal's filing.

In the final two avenues, it's "much more difficult" to prevail, says Ms. Wizmur. You can appeal to the Medicare Appeals Council, which generally "looks to see if one of the parties made an error or a decision that wasn't supported by the evidence."

The last recourse is to file a lawsuit in federal district court -- which the Medicare Rights Center has done only once.