

## federal news

## Challenging Part D Plan Coverage Decisions: The Exceptions and Appeals Processes

IF YOUR PATIENTS ARE having trouble accessing drugs under Medicare Part D, you may be able to help by filing an exception to initiate a plan's appeals process. Physicians are critical to the process because the plan will not begin reviewing an exception request until it receives the physician's supporting statement.

It's important to present a strong case at the first step in the appeals process, referred to as an "exceptions request," because with each step the length of time allowed to make a coverage determination grows. Also, drug plans are not required to provide temporary drug supplies while appeals are being considered.

Below are answers to some questions that may come up if you initiate a Medicare Part D appeal:

### Q: When is it appropriate to request an exception?

**A:** The exceptions and appeals process can be used to request coverage for drugs not included on a plan's formulary, to request that a drug be made available at a lower cost-sharing tier, and to waive utilization management policies such as step therapy or prior authorization.

The Centers for Medicare and Medicaid Services (CMS) also recommends that physicians request exceptions for any newly approved antiretrovirals that come to market if plans do not add them to their formularies expeditiously.

### Q: How long do plans have to process requests?

**A:** Plans are required to process expedited requests within 24 hours and standard requests within 72 hours. To file an expedited request, a physician needs to document that a patient's health will be threatened by delaying access to the medication in question.

### Q: Are all plans exceptions processes the same?

**A:** No. CMS sets basic standards for the exceptions and appeals processes but plans are given latitude within these parameters. For example, plans determine the amount and type of supporting documentation that they require to consider an exception. However, all plans are required to accept oral requests for expedited requests.

CMS is trying to facilitate a more uniform process across plans. The agency worked with the American Medical Association, the National Association of Health Plans, and others to develop a universal one-page exception form. CMS is encouraging plans to use the form, but they cannot require them to do so. The form is available online at: [http://www.cms.hhs.gov/MLNProducts/Downloads/Form\\_Exceptions\\_final.pdf](http://www.cms.hhs.gov/MLNProducts/Downloads/Form_Exceptions_final.pdf).

### Q: How long is a positive coverage determination good for?

**A:** Coverage decisions are valid for the remainder of the calendar year unless the patient switches to a new drug plan.

### Q: What if my initial request is turned down?

**A:** If an initial request is turned down, a patient has 60 days to ask for a "redetermination" by the drug plan. The plan has 72 hours to make a decision for expedited redetermination requests and 7 days for standard redetermination requests. Physicians are authorized to initiate an expedited redetermination request but must be appointed as an authorized representative to request a standard redetermination.

The patient or your office will need to contact the plan to learn what its process is for filing a redetermination request. If you are denied an exception related to ARV coverage, let CMS know.

Email [pmit@cms.hhs.gov](mailto:pmit@cms.hhs.gov) and copy HIVMA at [hivma@idsociety.org](mailto:hivma@idsociety.org) or call CMS at (202) 690-5907.

### Q: What's Next?

**A:** If a redetermination is turned down, patients can ask for a "reconsideration" that will be reviewed by a contractor hired by the drug plan to serve as an "independent review body (IRB)." The IRB is required to make a decision within 72 hours for expedited requests and 7 days for standard requests. IRB requests must be made in writing. Contact the plan to learn how to request review by the IRB.

If the IRB agrees with the plan's decision, your patient can request review by an administrative law judge (ALJ). Information on how to request an ALJ review should be included in the IRB denial notice. The ALJ has 90 days to review the case and make a decision. If the ALJ finding is unfavorable, patients or their representatives can request review by the CMS Medicare Appeals Council. The final step in the appeals process is to ask for review by a Federal court.

### Q: Can physicians submit appeal requests on behalf of their patients?

**A:** Physicians can request exceptions and expedited redetermination requests without officially being designated an authorized representative. Otherwise, patients must appoint you or another representative to act on their behalf. Patients should contact their plan to learn how to appoint a representative. Typically, plans require the completion of CMS Form 1696 for physicians or caregivers to be considered authorized representatives. ☒

### Important Resources

#### CMS Provider Site

Plan contact information, standard exceptions request  
[www.cms.hhs.gov/center/provider.asp](http://www.cms.hhs.gov/center/provider.asp)

#### CMS Guide on Filing an Exception

[www.medicare.gov/Publications/Pubs/pdf/11112.pdf](http://www.medicare.gov/Publications/Pubs/pdf/11112.pdf)

#### CMS Appointment of Representative Form

[www.cms.hhs.gov/CMSForms](http://www.cms.hhs.gov/CMSForms)

Click on CMS Forms on the left, Scroll down to CMS 1696

#### Medicare Rights Center

Sample exceptions letter:

[www.medicarerights.org/exceptionrequest\\_template.doc](http://www.medicarerights.org/exceptionrequest_template.doc)