AARP – The Bulletin Article

“Doc, have you ever had your credit card denied in the store?” I instantly remembered one Christmas season during my medical residency at the Macys in downtown Chicago. I was attempting to complete all of my holiday shopping on one of my off-days. “Well, how did you feel?” my patient followed up to ask me. I thought back to how the cashier politely informed me that my card had been denied. With no other forms of payment on me and a long line of inpatient, cold Chicagoans staring at me, I bolted for the door after mumbling something like, ‘I will be right back.’ I felt mortified, embarrassed, and confused. I later found out my credit card company was refusing the charges due to increased spending for the holidays in sharp contrast with the limited dollars a resident was able to spend the rest of the year. If I had patiently called my credit card company while in the store, I would have easily found that out; but, I was embarrassed and I got out of their ASAP!

My patient further explained that, how I felt at that moment was exactly how he felt when he was informed that a drug request was denied and he would have to pay the full fee. He explained this to me a month after I had given him a prescription for a blood pressure drug, and on return to my clinic for a routine follow-up had been found to have a persistently high blood pressure. Confused, I called the pharmacy to see if he had filled the drug and found out the drug had been denied since it was not covered by his health insurance. Angrily, I confronted him, asking why he didn’t call me back to let me know that the drug had been denied and he could not afford the cost. That is when he reminded me of my own experiences at being denied and not wanting to let others know that an item was too expensive.

My patient ended up being just fine. We worked together to find a drug that was on his Medicare drug formulary at a low cost and his blood pressure was adequately lowered. However, it did make me think, how many other patients like him did I have? How many others were too embarrassed to let me know their own confusion in the prescription drug process?

The Medicare insurance process can be overwhelming. I have seen the huge booklets beneficiaries receive when they enroll in a drug plan. It often seems the insurance companies make them purposely difficult to understand in an effort to make sure enrollees do not attempt to challenge a decision they have made! But, you have rights as a beneficiary of Medicare. One of those rights is the opportunity to appeal the decision a drug insurance plan has made in regards to your getting a prescription filled. This brief article will inform you of your own rights when a drug is denied and what you can do to ensure you do not end up running away like I did at the Macy’s counter.

What is a Drug Denial?

All individuals over the age of 65 are given the opportunity to enroll in Medicare Part D to get access to prescription drugs. All Medicare drug plans have a formulary – which includes drugs the insurance company will allow you to purchase at lower rates than it would be if you went to the pharmacy and tried to buy the drug without insurance. Sometimes, your
doctor will prescribe a drug for you that may not be on the lower costing formulary. If this is the case, your insurance company may deny you access to the drug at a reduced price.

*My drug request has been denied…Now What?*

You can still purchase the drug on your own if your insurance company tells you that your request to receive a drug at the lower price has been denied. However, you should inform your doctor immediately to see if they can prescribe you a similar drug that the insurance company does cover. If you choose to purchase the drug without your health insurance, you run the risk of the drug being extremely expensive.

At this time, if you are at the pharmacy counter you should ask the pharmacist to call your doctor to request a different drug. If the doctor’s office is closed, you can ask the pharmacy to give you just 1-3 pills to carry you over until you can call your doctor. This may be much cheaper than purchasing a full prescription without insurance. Most importantly, do not be embarrassed or guilty for alerting your physician about what has happened.

*What if I want to appeal the insurance company’s decision?*

Once your doctor knows that you were unable to receive your drug, she will likely prescribe you a different drug. However, at times, your doctor may not have any other options but to prescribe you that specific drug. This is especially common among the rheumatologic drugs (e.g. rheumatoid arthritis) or outpatient cancer drugs. If this occurs, your doctor can help you appeal the insurance company’s denial.

To appeal the coverage decision, it is easiest to call your insurance company and file it over the phone. Alternatively, you can request an appeal form and mail or fax it to the company. If you cannot do this by yourself, you can contact your State Health Insurance Assistance Program (SHIP) office. Each state has a main office with lawyers and medical experts who can walk you through the appeal process. Phone numbers and websites for each SHIP office can be found through the Medicare website (www.Medicare.gov) or by calling 1-800-MEDICARE. The employees at SHIP can help you with the all steps of the appeal.

*I filed an appeal. Now What?*

All enrollees have the right to appeal a decision by their drug company. There are five sequential levels that you can appeal through. As noted earlier, you can first appeal the coverage decision to your insurance company. By law, your insurance company can take no longer than 7 days to make a decision. If they do not notify you within 7 days, you should call them or contact the SHIP office to help you find out if a decision has been made. On average, 40% of appeals at this stage are overturned. Therefore, if you decide to file an appeal, you have a very good chance of having that decision overturned.

If the drug company decides to still not cover the drug, then you can appeal to independent agency called the Independent Review Entity (IRE). The IRE is not paid by the drug companies and is supposed to act as a non-biased evaluator. The IRE has 7 days to make a decision on your appeal. If the decision is denied, you can still appeal the decision, but you should probably ask for help from SHIP, a family member, or your physician as the next three levels of appeal can be time consuming. The next level of appeal is to an administrative law judge, then to the Medicare appeals council, then to a federal district court.
Remember, if your drug is denied at the pharmacy, don’t be embarrassed! Ask the pharmacist to call your doctor immediately and work with your physician to help you appeal the drug insurance company’s decision if necessary.

Three main take-away points to remember:
1. **Getting your healthcare provider (doctor, nurse, etc.) involved very early.** To win the first level of appeal (to your drug insurance company), you nearly always will need a note from your doctor explaining why you need this drug.
2. **Following up with the drug insurance company.** If your insurance company has not notified you within 7 days, they are required by law to forward the appeal to the next level.
3. **Finding help from family or friends if the language is difficult to understand.** The first time I helped one of my patients fill out her appeal form, it took me awhile. The words are big and confusing. There is no shame in asking a family member or friend to help you understand some of the language. It is better to fill out the form the first time than mess it up and have to fill it out again.

**JAMA Article**

A new calendar year is upon us and is frequently accompanied by a fresh new set of patient faces as individuals transfer into new insurance plans. As physicians, this can be a challenging time period. While attempting to learn the new additions to our panels, drug formularies often shift at this time, which can be incredibly frustrating for patients. Most vulnerable during this time period are seniors who may be enrolling in new Medicare Part D plans or have had a recent change in their drug formulary. Our Medicare beneficiary patients are often our most rewarding patients; and, at times our most challenging. Many of us may even think: “paperwork” when we see a new Medicare patient on our daily schedule. A particularly challenging issue that many of us are underprepared for is when a prescription drug is denied by their Medicare Part D plans. The beneficiary has a legal right to appeal this decision; however, many healthcare providers are unprepared or unwilling to help patients with this problem.

Many physicians and staff have dealt with some appeals system at some point; and if you are anything like the author, it often includes taking the path of least resistance and just prescribing a different drug that is covered. The Medicare Part D appeal process in particular can be extremely confusing. Past evaluations by the Kaiser Family Foundation have found beneficiaries often do not understand the process. Furthermore, a physician letter is nearly imperative for an individual to win an appeal at any level. As physicians, we must be prepared to help our patients navigate the appeals process in order for them to gain access to certain drugs. The remainder of this correspondence will explain the appeals process and how best to aid your Medicare patients.

**Background**

The Medicare Part D Prescription Drug Benefit Program is administered through private insurance organizations via either freestanding prescription drug plans (PDP) or through Medicare Advantage Organizations’ prescription drug plan (MADP) coverage. Both entities are required to create their own formulary including both lists of drugs and dosages.
Federal regulations require that at least two drugs be included in each major class and that there be an appeals process for enrollees to gain access to drugs outside of the formulary. The Medicare Part D appeals process is a multi-step course of action that enrollees can pursue if the drug plan denies coverage of a drug that is prescribed by their physician.

Beneficiaries can initially use the ‘coverage determination’ process to gain access to an off-formulary drug. Request of a coverage determination allows for prior authorization of a drug before a physician actually prescribes the drug. If an insurance company denies a coverage determination or if an attempt to fill a prescription at a pharmacy is denied by the insurance company, the beneficiary then has the opportunity to initiate an appeal. We as physicians are often the ones initiating the coverage determination (94% in GAO evaluation); however, appeals must be initiated by the beneficiary or an appointed representative (who can be a physician).

**Medicare Part D Appeals Process**

The majority of beneficiaries will find out a drug is not covered when they attempt to get the prescription filled at the pharmacy. Federal law requires the pharmacist either give the enrollee a printed standard notice from the PDP/MADP or have a standard notice posted within eyesight of the pharmacy counter from the PDP/MADP explaining what to do if a drug determination was adverse. The beneficiary then has the opportunity to appeal through a 5-step process: ‘redetermination’ through the PDP/MADP, ‘reconsideration’ through a Part D Independent Review Entity; and then, to an Administrative Law Judge, to the Medicare Appeals Council, and finally to the Federal District Court. At each level, the beneficiary is given a decision of ‘favorable,’ ‘adverse,’ and ‘partially adverse.’ If the decision is favorable, the PDP/MADP must subsequently pay for the drug. If the decision is partially adverse (e.g. agree drug should be covered, but at higher cost-sharing than requested) or adverse, the beneficiary has the opportunity to appeal to the next level.

At the first level, the redetermination level, the beneficiary or an advocate must file the appeal. However, to help your patient win the appeal, a physician should write a letter explaining why the patient needs the drug. KFF evaluation state that a letter is not required by the drug company; however, winning an appeal without this letter is nearly impossible. Once your patient has filed an appeal, they have a pretty good chance of winning. A prior evaluation by the GAO suggest that on average 2 out every 5 appeals are overturned and found in favor of the patient. Plans are required to make a decision at this level within 7 calendar days; or within 72 hours for drugs considered ‘lifesustaining’ (these drugs require written notice from a physician). If the drug plan does not meet these time guidelines they are required to automatically forward the appeal to the next appeal level.

If a claim is still denied at the redetermination level, the beneficiary can then request a ‘reconsideration’ to an Independent Review Entity. Once again, the beneficiary must initiate this request. Following an appeal to the IRE, the beneficiary can then appeal to an Administrative Law Judge (ALJ), then to the Medicare Appeals Council (which is an office within the U.S. Department of Health and Human Services), and finally to federal courts.
How We Can Help Our Patients
While the appeals process is a right given to all beneficiaries, it is estimate that very few beneficiaries appeal this decision. Even more concerning, is that many of our patients choose to just not follow through in an attempt to get a drug that has been denied. In addition to being aware of the appeals process, we can also direct our patients to organizations that are able to help them with appealing their coverage decision.

Each state has a state health insurance assistance program (SHIP). The phone number for your state’s office can easily be found through Google or some other search engine. The SHIP offices have trained staff, including lawyers, to help walk your patient through the appeals process. If a drug is considered medically necessary and the decision fails to be overturned at the first two appeal levels; the SHIP office can be especially helpful.

Conclusion
As a physician, my own anecdotal experience of talking with other young internal medicine physicians, is that we are grossly unaware that an appeals system exists and how to aid our patients in navigating such a system. Accordingly, we must work together to ensure that in this New year, our seniors are not left behind.

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Appendix 1 - References:


Lace, Daniel A. Medicare Part D: exceptions and appeals process. Managed Care. 2006; 15 (7): 13-17


Appendix 2 – The Journals
JAMA or Journal of the American Medical Association is an internationally circulated journal published since 1883 by the American Medical Association. Per the JAMA website, it is the “most widely circulated medical journal in the world.” JAMA is published weekly and features a wide variety of articles. The acceptance rate for JAMA is extremely low, 9% and they receive approximately 6,000 submissions a year.

The commentary section of the journal allows submissions in “medicine, public health, research, ethics, public policy, and law” and has a maximum of 1200 words of text. My article submission would be directed toward being published within this section.

My goals for the JAMA article include:
- Increase understanding for why the Medicare Part D appeals process is important.
- Provide specific resources healthcare professionals can use to help seniors.

AARP – The Bulletin is a 10 times a year publication funded by the American Association of Retired Persons or AARP. AARP has 37 million members who receive the Bulletin.

My goals for the AARP article include:
- Improve awareness of the Medicare Part D appeals process.
- Provide specific information for what to do if told their drug has been appealed.
- Provide potential contacts to aid seniors in the appeal process.