Medicare

Understanding Medicare Determination & Appeals Process

Coverage Determination Request

- Initial decision by plan
  - Which benefits they are entitled to receive
  - How much they must pay for a benefit
  - Themselves, their prescriber, or their appointed representative can request it
- Time frames for coverage determination requests may be
  - Standard (decision within 72 hours)
  - Expedited (decision within 24 hours) if life or health may be seriously jeopardized

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Exception Requests

- 2 types of exceptions
  1. Formulary exceptions (a type of coverage determination)
     - Drug not on plan's formulary, or
     - Access requirements (for example, step therapy)
  2. Tier exceptions
     - For example, getting a tier 4 drug at tier 3 cost
- Need supporting statement from prescriber
- Themselves, their appointed representative, or prescriber can make requests
- Exception may be valid for rest of year

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Requesting Appeals

- If they disagree with a coverage determination (including an exception) made by their plan or a coverage limitation under their plan's drug management program, they can appeal the plan's decision
- In general, they must make their appeal requests in writing
  - Plans must accept verbal expedited requests
- An appeal can be requested by
  - Themselves
  - Their doctor or other prescriber
  - Their appointed representative
- There are 5 levels of appeals

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