MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL
CHAPTER 18 ADDENDUM: Part D Enrollee Grievances, Coverage Determinations, and Appeals

80.7 Other Determinations Subject to Review
80.7.1 - Reconsideration of Late Enrollment Penalty Determinations
Rev. 1, 06-08-07

"Creditable prescription drug coverage" is prescription drug coverage that equals or exceeds the actuarial value of defined standard Part D prescription drug coverage; that is, creditable coverage is coverage that is at least as good as Medicare's prescription drug coverage. Creditable drug coverage may include but is not limited to: employer-based prescription drug coverage, including the Federal employees health benefits program (FEHBP); State Pharmaceutical Assistance Programs (SPAPs); military-related coverage (e.g., VA, TRICARE); and certain Medicare supplemental (Medigap) policies. (See 42 C.F.R §423.56(b) for a complete list of types of prescription drug coverage that may be determined to be creditable.) As outlined at 42 CFR 423.56(c) and (d), with the exception of Prescription Drug Plan Sponsors, Medicare Advantage Organizations, Section 1876 Cost-Based Contractors, and PACE organizations offering prescription drug plans, entities that offer prescription drug coverage must make an annual determination of creditable coverage status and provide a disclosure notice to Medicare eligible individuals.

Under §1860D-13(b) of the Social Security Act and 42 C.F.R. §§423.46 and 423.56(g), the Secretary or his or her designee imposes a late enrollment penalty (LEP) if there is a continuous period of 63 days or more at any time after the end of the individual's Part D initial enrollment period during which the individual was eligible to enroll in a Part D plan, but was not enrolled in a Part D plan and was not covered under any creditable prescription drug coverage. (See the appropriate plan enrollment guidance for information related to Part D enrollment eligibility. See Chapter 4 of this manual for additional guidance regarding creditable coverage period determinations and the calculation and assessment of the LEP.)

An enrollee, or his or her representative (as defined in §10.4 of this chapter), may request reconsideration of a decision to impose an LEP. Unless otherwise stated in §10.4 of this chapter, the enrollee's representative has all of the rights and responsibilities of an enrollee under Part D LEP reconsideration procedures.

An enrollee may seek reconsideration of an LEP for various reasons. For example, an enrollee may request LEP reconsideration on the basis that (1) there was an inaccurate determination of the number of months the individual was eligible to enroll, but was not enrolled, in a Part D plan (due to an erroneous conclusion drawn from the information provided, or due to an incorrect IEP end date); (2) the enrollee submitted a timely creditable coverage attestation form, or other creditable coverage documentation, but it was not considered;
(3) the enrollee did not receive an adequate notice that clearly explained whether his or her prescription drug coverage was creditable (and therefore, his or her prescription drug coverage

should be treated as creditable prescription drug coverage for the purpose of calculating the LEP); or (4) the enrollee has gotten extra help from Medicare for his or her prescription drug coverage, but he or she is not receiving the appropriate level of LEP subsidization from Medicare.

Note: Prescription drug discount cards, free clinics, or drug discount websites do not constitute creditable prescription drug coverage. Also, the "certificate of creditable coverage" an enrollee receives when most kinds of health coverage end is not adequate notice that prescription drug coverage is
as good as Medicare's prescription drug coverage, unless the notice specifically refers to the creditable coverage status of the enrollee's prescription drug coverage and the notice meets disclosure requirements outlined in the Creditable Coverage Guidance Paper posted on the CMS website at: http://www.cms.hhs.gov/creditablecoverage/10_ccafterfeb15.asp#topofpage

80.7.1.1 - Summary of the LEP Reconsideration Process

The LEP Reconsideration Process is described below:

- When a Part D plan sponsor first sends an enrollee a letter notifying him or her about the imposition of an LEP ("**LEP letter**"), the sponsor shall also include the **Part D LEP reconsideration notice: "Your Right to Ask Medicare to Review Your Medicare Part D Late Enrollment Penalty"** (Appendix 14). The Part D LEP reconsideration notice provides a detailed explanation of an enrollee's right to request reconsideration of his or her late enrollment penalty.

- The Part D plan sponsor shall also send the **LEP reconsideration request form** to enrollees at the same time it sends the beneficiary his or her initial LEP letter.

- The LEP letter, Part D LEP reconsideration notice, and the LEP reconsideration request form advise the enrollee that he or she has 60 calendar days from the date on the LEP letter to request reconsideration of the LEP, or the request may not be considered. If the 60-day timeframe for filing an LEP reconsideration has expired, the enrollee may request a good-cause extension, subject to the requirements described in §80.4 of this chapter. The enrollee must explain his or her reason for filing late on a separate sheet and send it along with the LEP reconsideration request form.

- The enrollee sends his or her signed, completed LEP reconsideration request form to an Independent Review Entity (IRE) under contract with Medicare, in accordance with the filing instructions provided on the form (Appendix 15). Enrollees also may use writing to request an LEP reconsideration, provided the writing contains the elements on the LEP reconsideration request form. At this time, the IRE is Medicare's appeals contractor.

- The IRE shall request a copy of the case file from the Part D plan sponsor and draft a recommended reconsideration decision based on the case file, the information supplied by the enrollee, and any other information that the IRE deems relevant.

- The IRE will inform the enrollee and the Part D plan sponsor of the final decision.

- The Part D plan sponsor shall report a revised creditable coverage determination to CMS and send the enrollee a letter informing him or her of the new LEP amount, and any refund due, if applicable.

- The final reconsideration decision is not subject to appeal (i.e., is not subject to further review by an Administrative Law Judge (ALJ), Medicare Appeals Council (MAC), or in a district court of the U.S.).

80.7.1.2 - Part D Plan Sponsor Responsibilities Under the LEP Reconsideration Process

The Part D plan sponsor shall become familiar with LEP procedures so it is able to assist enrollees throughout the LEP reconsideration process. For example, the Part D plan sponsor shall:

- Send the enrollee the **Part D LEP reconsideration notice**, "Your Right to Ask Medicare to Review Your Part D Late Enrollment Penalty" (Appendix 14), and the **LEP reconsideration request form** (Appendix 15) at the same time the plan sends an enrollee his or her initial LEP letter.

- Assist the enrollee in completing the LEP reconsideration request form. For example, the Part D plan sponsor shall help an enrollee determine if he or she has/had a special opportunity to enroll in Medicare Part D in 2006 and 2007 without an LEP as described in Section 80.7.1.4.

- Send the IRE a copy of the enrollee's case file, which includes copies of any information the plan used in making its creditable coverage determination for the enrollee, including, but not limited to: the enrollee's Part D IEP end date (and how it was derived), the enrollee's creditable coverage attestation form, and any documentation from CMS of the enrollee's enrollment in a Part D plan or in a plan whose sponsor received the retiree drug subsidy. (See Chapter 4 of this manual for specific guidance on information retention requirements related to creditable coverage and the LEP.)

80.7.1.3 - Elements of an LEP Reconsideration Request

The Part D plan sponsor shall inform the enrollee that his or her LEP reconsideration request must include the following elements:

- A completed, signed LEP reconsideration request form (Appendix 15) or a signed, written request for reconsideration containing the elements on the LEP reconsideration request form.

- If the enrollee has named a representative, proof that the individual has authority to represent the enrollee.

In addition to the items above, the Part D plan sponsor shall inform the enrollee that his or her LEP reconsideration request should include:

- Any additional information that may help the enrollee's case, including evidence of special circumstances that the IRE should consider (see §80.7.1.4).

80.7.1.4 - Reasons for Requesting LEP Reconsideration and Presentation of Evidence

Enrollees may request their LEP reconsideration decision be reviewed for several reasons, including, but not limited to –

- An enrollee claims he or she did not receive a notice that clearly explained whether the prescription drug coverage the individual had after he or she was first eligible to sign-up for a Medicare prescription drug plan was creditable. In this case, the enrollee should submit any evidence, such as a copy of an organization's letter or other material, e.g., a Summary of Benefits that the enrollee found unclear or misleading.

- An enrollee claims he or she had a special opportunity to enroll in Medicare Part D in 2006 and 2007 without an LEP. Medicare beneficiaries who qualify for the low-income subsidy for Medicare prescription drug coverage may enroll in a Medicare prescription drug plan with no penalty through December 31, 2007. Also, certain Medicare beneficiaries who were affected by Hurricane Katrina were allowed to enroll in a Medicare prescription drug plan with no penalty through December 31, 2006 if, at the time of the hurricane (August 2005), they resided in any of the parishes or counties declared as meeting the level of "individual assistance" by the Federal Emergency Management Agency (FEMA). FEMA has identified the parishes and counties declared eligible for "individual assistance" as a result of Hurricane Katrina. The list of parishes and counties can be found at www.fema.gov/news/disasters.fema?year=2005 on the web. Refer to the Chapter 4 Appendix for additional guidance on the opportunity for certain individuals to enroll in Medicare Part D without an LEP.

Enrollees may also request a reconsideration if they believe they should not have to pay an LEP due to "special circumstances." For example, an enrollee could claim that there was an inaccurate determination of the number of months that the individual was eligible to enroll, but was not enrolled, in a Part D plan. This may be because the enrollee was not eligible to join a Medicare Part D when she lived abroad because she did not reside in a Part D plan service area. Alternatively, a beneficiary could claim that the determination of the number of months between the end of his Part D enrollment period and the effective date of coverage is wrong because his Part D initial enrollment period end date was later than indicated by the Part D plan sponsor. In these cases, the beneficiary should submit proof; e.g., evidence of overseas residency, including timing and location of residency.

If additional information can help explain why an enrollee's LEP is incorrect, he or she should submit such proof with the LEP reconsideration request form. Enrollees are asked to send to Medicare's appeals contractor any proof that helps explain their reasons for requesting an LEP reconsideration. If an enrollee believes his or her LEP is wrong due to other special circumstances, he or she should select the last checkbox on page 1 of the LEP reconsideration request form, describe the special circumstances on a separate page, and attach this to the LEP reconsideration request form. Part D plan sponsors shall instruct the enrollee to send this material to Medicare's appeals contractor at the address or fax number shown on page 2 of the LEP reconsideration request form, to include their Medicare Health Insurance Claim number on any separate materials, and to only send photocopies of their original documents.

80.7.1.5 - LEP Reconsideration Process Timeline

Below is a summary of the timelines the IRE generally will follow during the LEP reconsideration process:

- Unless the IRE finds good cause to extend its decision-making timeframe, the IRE generally will notify the enrollee of the final LEP reconsideration decision (including a decision to dismiss the reconsideration request), within 30 calendar days of receiving an enrollee's request for reconsideration.

- The IRE may take an additional 14 days if the enrollee requests an extension or if the IRE finds good cause to extend the timeframe. Good cause would include, for example, when the IRE finds a need for additional information and considers the delay to be in the interest of the enrollee, such as receipt of additional information that may reduce the number of uncovered months upon which the LEP was based.

- In cases where an individual other than the enrollee files for reconsideration, the reconsideration timeframe will not commence until the IRE receives documentation verifying that the individual is the enrollee's representative or is authorized under state law to act on behalf of an enrollee, as described in §10.4 of this chapter. The IRE will attempt to cure any defect in an Appointment of Representative form (CMS-1696) or other equivalent written notice – e.g., the form or notice was not properly executed – by requesting information from the individual who filed the reconsideration. If the IRE cannot verify an individual's status as the representative within a reasonable time period, not to exceed 30 calendar days after the date of the reconsideration request, the IRE will determine that the reconsideration request be dismissed.

80.7.1.6 - Withdrawal of an LEP Reconsideration Request

An enrollee may withdraw his or her LEP reconsideration request in writing at any time before the IRE mails the final decision. For purposes of a withdrawal, "enrollee" also includes a former enrollee or his or her representative.

80.7.1.7 - Dismissal of an LEP Reconsideration Request

Instances in which the IRE may determine that a reconsideration request be dismissed include, but are not limited to, the following:

- An enrollee failed to request a timely LEP reconsideration and did not have good cause for missing the filing deadline.

- An enrollee dies while the reconsideration is pending and the enrollee's surviving spouse or estate has no remaining financial interest in the reconsideration.

- An individual requesting the reconsideration is not the enrollee, and the authority of the individual seeking a reconsideration cannot be verified within a reasonable time period, not to exceed 30 calendar days after the date of the reconsideration request.

- An enrollee requests a reconsideration of an issue that is ineligible for LEP reconsideration. For example, the IRE will not make actuarial determinations concerning whether an enrollee's prescription drug coverage was creditable; i.e., an enrollee may not use the LEP reconsideration process to seek review of the decision that his or her coverage under an employer-sponsored prescription drug plan was not creditable coverage.

80.7.1.8 - Requests for Information

- Upon request, the Part D plan sponsor shall forward to the IRE any information necessary to make a reconsideration decision, including all creditable coverage and LEP-related information received in accordance with Chapter 4 of this manual, such as information from a current or previous enrollee.

- Upon request, the Part D plan sponsor delivers (by mail or fax) a hard copy of the requested information within two business days after receiving the request for information. Requested information may include, for example, an enrollee's attestation form, including forms received late.

    - In the event a Part D plan sponsor has no information to forward, the Part D plan sponsor shall deliver (by mail or fax) a brief letter to the IRE within two business days after receiving the request for information. The letter acknowledges that the requested information is unavailable and explains the reason; e.g., the enrollee never submitted an attestation form.

80.7.1.10 - Dismissals

Dismissals are not appealable.

80.7.1.10.1 - Vacating a Dismissal

The dismissal is binding, unless the dismissal is vacated. If a Part D enrollee requests the dismissal be vacated and he or she shows good cause that the reconsideration request should not be dismissed, the dismissal of the reconsideration request may be vacated. The enrollee must request that the dismissal be vacated within 60 days after the date of the dismissal notice. The IRE will notify the enrollee and the Part D plan sponsor in writing if the dismissal is vacated.

80.7.1.11 - Requirements Following LEP Reconsideration

80.7.1.11.1 - IRE Responsibilities

The IRE will notify the enrollee and the Part D plan sponsor of the final reconsideration decision generally within 30 calendar days after receiving the enrollee's request for reconsideration. If an enrollee has identified a representative, the IRE will send any notice or other correspondence required under §80.7.1 to the individual's representative instead of to the enrollee.

80.7.1.11.2 - Part D Plan Sponsor Responsibilities

If the IRE partially or fully reverses a Part D plan sponsor's creditable coverage determination, the Part D plan sponsor shall comply with the requirements described under Chapter 4 of this manual.

Appendix 14 – Model Part D Late Enrollment Penalty Reconsideration Notice
(Rev. 1, 06-04-07)

YOUR RIGHT TO ASK MEDICARE TO REVIEW YOUR MEDICARE PART D LATE ENROLLMENT PENALTY

What if I Don't Agree with Medicare's Late Enrollment Penalty Decision?

If you don't join a Medicare drug plan when you are first eligible, you may have to pay a late enrollment penalty (LEP) unless you had creditable prescription drug coverage (as good as Medicare's). You have the right to ask Medicare to look at, or "reconsider," your late enrollment penalty decision. This is called a "reconsideration." For example, you could request a reconsideration if you think Medicare did not count all of your creditable coverage or if you didn't get a notice that clearly explained whether your previous prescription drug coverage was creditable.

Who Can Ask for a Reconsideration?

You or someone you name to act for you (your representative) can ask for a reconsideration. If someone requests a reconsideration for you, he or she must send proof of his or her right to represent you with the request form. Proof could be a power of attorney form, a court order, or an "Appointment of Representative" form. This last form can be found at http://www.medicare.gov/Basics/forms on the web. You also can call the Medicare helpline (see below) and ask for Form CMS-1696.

How Do I Ask for a Reconsideration?

The reconsideration request form is sent with this notice. Complete the form. Mail it to the address or fax it to the number listed on the form within 60 days from the date on the letter you got stating you had to pay a late enrollment penalty. You should also send any proof that supports your case, like information about previous creditable prescription drug coverage. If you wait more than 60 days, you must explain why your request is late. Medicare will decide if you had good cause to send a late request.

What Do I Need to Include with My LEP Reconsideration Request?

1. A completed, signed LEP reconsideration request (keep a copy).
2. Copies of information you believe may help your case.
3. If you've named someone to act for you, a copy of the proof the individual can represent you.

NOTE: Do not send original documents.

Where Can I Get More Information?

Call <Plan Name> at <plan toll-free number> <days and hours of operation>. TTY users should call the plan at <plan TTY number>. *<A plan also may include a URL to its website here to provide additional information.>* Or, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for help. TTY users should call Medicare at 1-877-486-2048.

Appendix 15 – Model Part D Late Enrollment Penalty Reconsideration Request Form
(Rev. 1, 06-04-07)

LATE ENROLLMENT PENALTY RECONSIDERATION REQUEST FORM

Date: _____ **Enrollee Name**: _____

Address: _____

Phone: (_____)_____

Medicare Health Insurance Claim # (From red, white and blue Medicare card): _____

Name of Medicare Prescription Drug Plan: _____

IMPORTANT: Complete, sign and mail this request to the address or fax it to the number listed on the form within 60 days from the date on the letter you got stating you had to pay a late enrollment penalty. If it has been more than 60 days, explain your reason for delay on a separate sheet and send it with this form**.**

Check all boxes that apply to you:

☐ I had prescription drug coverage but **I didn't get a notice that clearly explained if my drug coverage was creditable** coverage (as good as Medicare's).

Reminder: Most non-Medicare plans that offer prescription drug coverage, like employer or union coverage, must send enrollees a notice explaining how their prescription drug coverage compares to Medicare prescription drug coverage (whether their coverage was creditable). Plans may provide this information in their benefits handbook or as a separate written notice.

If you don't know if your prescription drug coverage was creditable: To help your case, you may want to send a letter to your previous plan and ask if your coverage was creditable. Attach your letter and any response to this form. You should not wait to receive a response before you send this request form, and there is no need to send a letter if you were enrolled in a Medicare Part D plan.

☐ **I had creditable prescription drug coverage.** List the plan(s) and all dates you were covered. Include the address and phone number for each plan if you have them. Use a separate sheet if necessary.

Plan Name: _____ Dates of coverage: from _____to _____

Plan Address & Phone: _____

☐ **At the time of Hurricane Katrina (August 2005), I lived in a parish or county declared eligible for "individual assistance," and I joined a Medicare drug plan before December 31, 2006.** (Check this box even if you joined a Medicare drug plan in 2006, but your drugs weren't covered until Jan. 1, 2007.)

☐ **I got/get extra help from Medicare to pay for my prescription drug coverage.**

Date(s) of extra help: from _____to _____. Use a separate sheet if necessary.

☐ **I believe the LEP is wrong for other reasons not listed above.** Briefly explain your reason(s) on a separate page and attach any proof to this form.

By signing this form, I give permission to any entity to release information needed by Medicare to review my Medicare prescription drug late enrollment penalty.

_____ _____

Signature of Person Requesting Reconsideration (either Enrollee or Representative) **Date**

I certify that the information on this form is true, accurate and complete. I understand that if I have submitted any false documents, made any false claims or statements, or concealed any material facts, I may be subject to civil or criminal liability.

- OVER –

Important: Prescription drug coverage is **insurance**. It's NOT doctor samples, discount cards, free clinics, or drug discount websites.

Also, the "certificate of creditable coverage" that you may have received when your health coverage ended doesn't mean that your prescription drug coverage was as good as Medicare's standard prescription drug coverage – unless the notice specifically mentioned that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

To Help Your Case: Send any proof with this form that helps explain your reason for requesting reconsideration. This is your opportunity to explain why you believe your late enrollment penalty is wrong. Be sure to include your Medicare Health Insurance Claim number on materials you send.

Complete the following section only if the person making this request is NOT the enrollee:

Representative Name:_____
Address:_____ **Phone:** (____) _____
Relationship to Enrollee: _____

Send this form and any extra pages to:

MAXIMUS (Medicare's Appeals Contractor)

<Plans:Insert appropriate address based on your plan type>

PDP Plans:
MAXIMUS
1040 First Avenue, Suite 200
King of Prussia, PA 19406
Fax: (484) 688-5601

MA-PD Plans:
MAXIMUS
50 Square Drive, Suite 120
Victor, NY 14564
Fax: (585) 425-5301

Be sure to include your Medicare Health Insurance Claim number on any materials you send. Do not send original documents.

Where Can I Get More Information? Call <Plan Name> at <plan toll-free number> <days and hours of operation>. TTY users should call the plan at <plan TTY number>. *<A plan also may include a URL to its website here to provide additional information.>* Or, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call Medicare at 1-877-486-2048. The list of parishes and counties that FEMA declared eligible for "individual assistance" as a result of Hurricane Katrina can be found at www.fema.gov/news/disasters.fema?year=2005

STOP! DID YOU SIGN THIS FORM?