

Prescription Drug Appeals and Grievances: What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Customer Service at 1-888-445-8916 (for TTY/TDD, call 1-888-844-5530).

This document gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. This information is also included in the Evidence of Coverage booklet. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from SmartValue or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make.

An **“appeal”** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what prescription drug benefits are covered for you or what we will pay for a prescription drug.** For example, if we refuse to cover or pay for a prescription drug you think we should cover, you can file an appeal. If SmartValue refuses to authorize benefits for a prescription drug you think should be covered, you can file an appeal. If SmartValue reduces or cuts back on the prescription benefits you have been receiving, you can file an appeal. If you think we are stopping your prescription drug coverage too soon, you can file an appeal.

A **“grievance”** is the type of complaint you make **if you have any other type of problem with SmartValue or one of our network pharmacies.** For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or getting the information you need, or the cleanliness or condition of a network pharmacy.

How to file a grievance

A grievance is different from an appeal because usually it will not involve coverage or payment for Part D prescription drug benefits (*concerns about our failure to cover or pay for a certain drug should be addressed through the appeals process detailed below*).

What types of problems might lead to you filing a grievance?

- If you feel that you are being encouraged to leave (disenroll from) SmartValue.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to make a decision within the required time frame.
- Failure to forward your case to the independent review entity if we do not make a decision within the required time frame.

In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

Filing a grievance with SmartValue

If you have a grievance, we encourage you to first call Customer Service at 1-888-445-8916 (for TTY/TDD, call 1-888-844-5530). We will try to resolve any complaint that you might have over the phone. You may submit your complaint in writing to:

SmartValue
 Appeals and Grievances
 P.O. Box 9154
 Oxnard, CA 93031-9154

If you request a written response to your phone complaint, we will respond to you in writing. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Grievance Procedure. Expedited grievances can be filed concerning decisions to not conduct expedited organizational determinations or reconsiderations or to take extension on initial decisions or appeals. The Plan must respond to an enrollee’s expedited grievance within 24 hours. Standard grievances will be notified of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

How to appeal

This section explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to appeal our decision. We use the word “provide” in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that

you have been getting. Problems getting a Part D prescription drug that you believe we should provide include the following situations:

- If you are not getting a prescription drug that you believe may be covered by SmartValue.
- If you have received a Part D prescription drug you believe may be covered by SmartValue while you were a member, but we have refused to pay for.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a “formulary”). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the co-payment we require you to pay for a drug.
 - You have requested an exception to our formulary or to the co-payment for a drug and we have denied your request.
 - If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.
 - We do not make a decision on your request within the required time frame.

Requesting an appeal from SmartValue

If you are having a problem getting a Part D benefit or payment for a Part D prescription drug that you have already received, you can request an appeal. After we have made the initial coverage determination, there are five levels of appeal. At each level, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to ask for the next level of appeal if you want to continue requesting the benefit or payment. Each appeal level is discussed in greater detail below and in the Evidence of Coverage booklet.

How to request an appeal

This section gives you more information about how to appeal a decision by us not to cover or pay for all or part of a drug, vaccine, or other Part D benefit. There are five levels to the appeals process. This section goes through each step in detail.

What kinds of decisions can be appealed?

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not reimburse you for a Part D drug that you paid for. In addition, if you think we should have paid or reimbursed you more than you

received, or the amount you are paying is more than you are supposed to pay under the plan, you can appeal. Finally, if we deny your exception request, you can appeal. Here are some examples of situations where you might want to file an appeal:

- If you are not getting a prescription drug that you believe may be covered by SmartValue.
- If you have received a Part D prescription drug you believe may be covered by SmartValue while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a “formulary”). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the co-payment we require you to pay for a drug.
- You have requested an exception to our formulary or to the co-payment for a drug and we have denied your request.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.
- We do not make a decision on your request within the required time frame.

Please Note: *If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment we require you to pay for the drug.*

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

Moving from one level to the next. At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

“Initial decision” vs. “making an appeal.” Whenever you ask for a Part D benefit, the first step is called an “initial decision” or a “coverage determination.” If you are unhappy with the initial decision, you can ask for an appeal, which is called a redetermination. There are also four other levels of appeal that an enrollee may request.

Who makes the decision at each level. You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make an initial decision. If our initial decision is to turn down your request (in whole or in part), you can go on to the first level of appeal by asking us to review our initial decision. If you are still dissatisfied with the outcome, you can ask for further review. If you do, **your appeal is then sent outside of SmartValue, where people who are not connected to us conduct the review and make the decision.** After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Initial Decision: SmartValue makes an “initial decision” about your Part D prescription drug, or about paying for a Part D prescription drug you have already received.

What is an “initial decision”?

The “initial decision” made by SmartValue is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact SmartValue and ask us for an initial coverage decision. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. (This “initial decision” is sometimes called a “coverage determination.”) If our initial decision is to deny your request (this is sometimes called an “adverse coverage determination”), you can “appeal” the decision by going on to Appeal Level 1 (see below). If we fail to make a timely “initial decision” on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

- You ask us to pay for a prescription drug you have already received; this is a request for an “initial decision” about payment. You can call us at 1-888-445-8916 to get help in making this request.
- You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"), this is a request for a "formulary exception." A "formulary exception" is a type of "initial decision." You can call us at 1-888-445-8916 to ask for this type of decision.
- You ask for an exception to our plan's utilization management techniques. These are also considered to be requests for “formulary exceptions,” and are a type of “initial decision.” You can call us at 1-888-445-8916 to ask for this type of decision.
- You ask for a non-preferred Part D drug at the preferred cost level, this is a request for a "tiering exception." A "tiering exception" is a type of "initial decision." You can call us at 1-888-445-8916 to ask for this type of decision.
- You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the plan. You can call us at 1-888-445-

8916 to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

When we make an "initial decision," we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of SmartValue apply to your specific situation. The Evidence of Coverage booklet and any amendments you may receive as a member of SmartValue describe the Part D prescription drug benefits covered by SmartValue, including any limitations that may apply to these benefits. The Evidence of Coverage booklet also lists exclusions (*benefits that are "not covered" by SmartValue*).

Who may ask for an "initial decision" about a Part D benefit or payment?

You can ask us for an initial decision yourself, or your prescribing physician or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at SmartValue, Appeals and Grievances, P.O. Box 9154, Oxnard, CA 93031-9154. You can call us at 1-888-445-8916 to learn how to name your appointed representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service.

"Standard decisions" vs. "fast decisions"

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover a Part D prescription drug can be a "standard decision" that is made within the standard time frame (typically within 72 hours; see below), or it can be a "fast decision" that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should mail or deliver a request in writing to the following address: SmartValue, Appeals and Grievances, P.O. Box 9154, Oxnard, CA 93031-9154.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a “fast” decision (rather than a “standard” decision) by calling us at 1-888-445-8916 (for TTY/TDD, call 1-888-844-5530). Or, you can deliver a written request to SmartValue, Appeals and Grievances, P.O. Box 9154, Oxnard, CA 93031-9154. For a “fast decision” during non-office hours, please call 1-888-445-8916 and leave a message. Be sure to ask for a “fast,” “expedited,” or “24-hour” review.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 72 hours; see below).

What happens when you request an “initial decision?”

What happens, including how soon we must decide, depends on the type of decision.

1. *For a standard initial decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

Generally, we must make our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, an exception from utilization management rules – such as dosage or quantity limits or step therapy requirements—or a tiering exception), we must make our decision no later than 72 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

We will tell you in writing of our initial decision concerning the prescription drug you have requested. You will receive this notification when we make our decision under the time frame explained above. If we do not approve your request, we

must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. *For a fast initial decision about a Part D drug that you have not received.*

If you receive a "fast" review, we will give you our decision within 24 hours after you or your doctor ask for a "fast" review—sooner if your health requires. If your request involves a request for an exception, we must make our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will tell you in writing of our initial decision concerning the prescription drug you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your physician's request for a "fast" review, we will make our decision within the "standard" 72- hour time frame discussed above. If we tell you about our decision not to provide a "fast" review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a "fast" review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a "fast" review.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we have received your physician's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

2. *For a fast decision about a Part D drug that you have not received.*

We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we have received your physician's "supporting statement."

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If any initial decision does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1)

Appeal Level 1: If we deny part or all of your request in our initial decision, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."

Please call us at 1-888-445-8916 if you need help with filing your appeal. You may ask us to reconsider our initial decision, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to people at our organization who were not involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision*. Please see the discussion under, "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision."

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information. You can give us your additional information in any of the following ways:

WRITE SmartValue
Appeals and Grievances,
P.O. Box 9154
Oxnard, CA 93031-9154

FAX 1-818-234-4084

CALL *(if it is a "fast" appeal)* 1-888-445-8916

IN PERSON 2100 Corporate Center Drive, Newbury Park, CA 91320

You also have the right to ask us for a copy of information regarding your appeal. You can call us or write us at the contact information given above.

How do you file your appeal of the initial decision?

The rules about who may file an appeal are almost the same as the rules about who may ask for an "initial decision." Follow the instructions under "Who may ask for an 'initial decision' about medical care or payment?" The only difference between asking for an initial decision and the first level of appeal is that your prescribing physician may only request a "fast" appeal, unless you appoint (or have already appointed) your prescribing physicians as your appointed representative.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our initial decision. We can give you more time if you have a good reason for missing the deadline. To file a "standard" appeal, you can call us at 1-888-445-8916 or send the appeal to us in writing at SmartValue, Appeals and Grievances, P.O. Box 9154, Oxnard, CA 93031-9154. To file a "fast" appeal, you can call us at 1-888-445-8916 or send the appeal to us in writing at SmartValue, Appeals and Grievances, P.O. Box 9154, Oxnard, CA 93031-9154.

What if you want a "fast" appeal?

The rules about asking for a “fast” appeal are the same as the rules about asking for a “fast” initial decision. If you want to ask for a “fast” appeal, please follow the instructions under “Asking for a fast decision.” Remember, that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.*

After we receive your appeal, we have up to 7 calendar days to make a decision, but will make it sooner if your health condition requires us to. If we do not tell you our decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

2. *For a fast decision about a Part D drug that you have not received.*

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires us to. If we do not tell you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

We must send payment to you no later than 30 calendar days after we receive your request to reconsider our initial decision.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal.

3. *For a fast decision about a Part D drug you have not received.* We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal -- or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization to review your case. This independent review organization contracts with the Federal government and is not part of SmartValue.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must you file your appeal?

You must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to Lumetra, One Sansome Street, Suite 600, San Francisco, CA 94104-4447.

What if you want a “fast” appeal?

The rules about asking for a “fast” appeal are the same as the rules about asking for a “fast” initial decision. If you want to ask for a “fast” appeal, please follow the instructions under “Asking for a fast decision.” Remember that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, the IRE will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it received your request to make a decision.
2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it receives the request to make a decision.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about reimbursement for a Part D drug you already paid for and received. We must pay within 30 calendar days from the date we receive notice reversing our initial decision. We will also send the independent review organization a notice that we have abided by their decision.*

2. *For a standard decision about a Part D drug you have not received. We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our initial decision. We will also send the independent review organization a notice that we have abided by their decision.*

For a fast decision about a Part D drug you have not received. We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our initial decision. We will also send the independent review organization a notice that we have abided by their decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is \$100.00 or more.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge (ALJ). You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You must send your written request to [IRE Independent Review Entity and mailing address].

1. The ALJ office will schedule your hearing in a place close to your home. The ALJ office will tell you the time and place of the hearing.
2. You go to the hearing and present your case. Your health plan may also have someone at the hearing to give information. You can bring anyone with you to speak for you or help you. This person does not have to be a lawyer. You can pick anyone, such as a family member, friend, or doctor.
3. The ALJ makes a decision based on your case file and the information given at the hearing.
4. The ALJ sends the written decision to you, your health plan, and to MAXIMUS CHDR.
5. If the ALJ agrees with you, then MAXIMUS CHDR will send a letter to your health plan telling them to pay or provide benefits for your health care.

You may request that the Administrative Law Judge extend this deadline for good cause. During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than \$100.00. If the dollar value is less than \$100.00, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to that point, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received. We must send payment to you no later than 30 calendar days from the date we receive notice reversing our initial decision.*

2. *For a standard decision about a Part D drug you have not received. We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our initial decision.*

For a fast decision about a Part D drug you have not received. We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our initial decision.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by a Medicare Appeals Council

The Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you can request review by the Council.

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action

taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.* We must send payment to you no later than 30 calendar days from the date we receive notice reversing our initial decision.
2. *For a standard decision about a Part D drug you have not received.* We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our initial decision.
3. *For a fast decision about a Part D drug you have not received.* We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our initial decision.

If the Council decides against you:

If the amount involved is \$100.00 or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than \$100.00, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount is \$100.00 or more, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we receive notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received. We must send payment to you within 30 calendar days from the date we receive notice reversing our initial decision.*
2. *For a standard decision about a Part D drug you have not received. We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our initial decision.*
3. *For a fast decision about a Part D drug you have not received. We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our initial decision.*