

SECTION 6 Appeals and Grievances: what to do if you have complaints

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call our Customer Services at 1-800-547-0421.

This section 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. 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 someone makes a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from our Plan or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us, or one of our nonpreferred network retail pharmacies that does not relate to coverage for a prescription drug. 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 a pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy. This section contains more information about grievances including how to file a grievance.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you must contact us if you want to request a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination for a covered Part D drug. **You cannot request an appeal if we have not issued a coverage determination.** If we issue an unfavorable coverage determination, you may file an appeal if you want us to reconsider our decision. If our redetermination is unfavorable, you have additional appeal rights that are described in this section.

How to file a grievance

This part of Section 6 explains how to file a grievance. A grievance is different from a request for a coverage determination because it usually 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 coverage determination process discussed in this section).

If you have a grievance, we encourage you to first call Customer Services at 1-800-547-0421. We will try to resolve any complaint that you might have quickly over the phone.

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

- You feel that you are being encouraged to leave (disenroll from) our Plan.
- 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 a 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 give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by our Plan sponsor to provide required notices.
- Failure to provide required notices that comply with CMS standards.

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 grievances in more detail in this section.

- If you have a grievance, please call Customer Services at 1-800-547-0421 first. We will try to resolve any complaint that you might have quickly over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.
- We must notify you 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 timeframe 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.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare Prescription Drug Plan under the grievance process, by an independent organization called the QIO, or by both. For any complaint filed with the QIO, we must cooperate with the QIO in resolving the complaint.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. A member who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See the Introduction for more information about how to contact and file a quality of care complaint with the QIO.

How to request a coverage determination

The purpose of this section is to explain what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. 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.

What is a coverage determination?

The coverage determination made by our Plan 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 us and ask for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request for a Part D drug, you can appeal our decision by going on to Appeal Level 1 (in this section). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review under Appeal Level 2 (in this section).

The following are examples of coverage determinations:

- You ask us to pay for a drug that you have already received. This is a request for a coverage determination about payment. You can call Customer Services at 1-800-547-0421 to get help in making this request.
- You ask for an exception to our Plan's utilization management tools - such as preauthorization for a compounded drug, or quantity limits. Requesting an exception to a utilization management tool is a type of formulary exception. See *What is an exception* in this section.
- You ask for a Tier 3 drug at the Tier 2 cost sharing level. This is a request for a *tiering exception*. See *What is an exception* in this section.
- You can ask us to reimburse you for a drug you bought at an out of network pharmacy. In certain circumstances, out of network prescriptions, including drugs provided to you in a doctor's office will be covered. See Section 1 for a description of these circumstances and how to file a paper claim.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits apply to your specific situation. This document and any amendments you may receive describe the Part D prescription drug benefits covered by our Plan, including any limitations that may apply to these benefits.

What is an exception?

An exception is a type of coverage determination. You can ask us to make an exception to our coverage rules in the following types of situations:

- Since all Part D drugs are on our formulary, there would be no reason to ask for an exception to our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in Tier 3, you can ask us to cover it at the cost-sharing amount that applies to Tier 2. You may not ask us to change the cost-sharing amounts for Tiers 1, 2 and 4.
- Your physician must submit a Statement supporting your exception request. In order to help us make a decision more quickly, you also need to include supporting medical information from your doctor when you submit your written exception request.

Generally, if we approve your exception request, our approval will be valid for the remainder of our Plan year if your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision.

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing doctor 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: UPREHS, PO Box 165090, Salt Lake City, UT 84116-5090. You can call Customer Services to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination 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. There are also groups that will give you free legal services if you qualify.

Asking for a standard decision about a Part D drug

To ask for a standard decision, you, your doctor, or your appointed representative can call our Customer Services at 1-800-547-0421. Generally, your request can be handled at the time you call us.

Asking for a fast decision about a Part D drug

You, your doctor, or your appointed representative can ask us to give you a fast decision rather than a standard decision by calling Customer Services at 1-800-547-0421. Be sure to ask for a fast, expedited, or 24-hour review. You cannot get a fast decision if it is for a drug you have already received.

- 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 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 decision, we will let you know very quickly.

What happens when you request a coverage determination?

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

1. For a *standard* coverage determination about a Part D drug, which includes a request about payment for a *Part D drug that you already received*.
 - Generally, you will get a decision when you call our Customer Services. Usually, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires.
 - If your request involves a request for a tiering exception or an exception from quantity limits or preauthorization, we must make our decision no later than 72 hours after we have received your doctor's supporting Statement.

We will give you a decision in writing or over the telephone (whichever is quicker) about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Appeal Level 1 explains how to file this appeal.

2. For a *fast* coverage determination about a *Part D drug that you have not received*.
 - Generally, you will get a decision when you call our Customer Services. If you get a fast decision, we must give you our decision no later than 24 hours after you or your doctor ask for a fast decision – sooner if your health requires.
 - If your request involves an exception, we must make our decision no later than 24 hours after we get your doctor's supporting Statement explaining why you need the exception.

We will give you a decision over the telephone or in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Appeal Level 1 explains how to file this appeal.

If we decide you are eligible for a fast decision and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2.

If we do not grant your or your doctor's request for a fast review, we will give you our decision within the standard 72- hour timeframe discussed above. If we tell you about our decision not to provide a fast review by telephone, we may not send you a letter unless you ask for one. You can file a grievance if you disagree with our decision to deny your request for a fast review. We will automatically give you a fast decision if you get a doctor's support for a fast decision.

What happens if we decide completely in your favor?

If we make a coverage determination 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 prescription 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 prescription no later than 72 hours after we get your doctors' supporting Statement. If you are requesting reimbursement for a drug that you already paid for and received, we must send you payment within 30 days.
2. For a *fast* decision about a *Part D drug that you have not received*.
 - We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 24 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 24 hours after we get your doctor's supporting Statement.

What happens if we deny your request?

If we deny your request we will call you or send you a letter explaining the reason why your request was denied. We may decide completely or only partly against you. For example, if we deny your request for payment for a Part D prescription that you have already received, we may say that we will pay nothing or only part of the amount you requested. Remember, UPREHS will reimburse you only for our cost of the drug minus your copayment for out of network prescriptions. You would not be able to appeal the remaining charges from the out of network pharmacy. If we decide to pay nothing for the Part D drug, you can appeal.

How to request an appeal

This part explains what you can do if you disagree with our coverage determination or exception request. If you are unhappy with our coverage determination decision, you can ask for an appeal called a redetermination. You can generally appeal our decision not to cover a Part D drug, vaccine or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for, or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a Part D prescription. Finally, if we deny your exception request, you can appeal.

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 appeal 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.

- **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 a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of our Plan, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, someone who is connected to the Medicare program or the Federal court system will decide all subsequent levels of appeal. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail in this section.

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

Please call Customer Services at 1-800-547-0421 if you need help with filing your appeal. You may ask us to reconsider our coverage determination for a Part D drug, even if only part of our decision is not what you requested. When we get your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. 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, a tier exception request or an exception to utilization quantity limits. 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 *coverage determination*. Please see those discussions in this section.

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 get 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:

- In writing: UPREHS Prime Medicare Plan Appeals, PO Box 165090, Salt Lake City, UT 84116-5090
- By fax: UPREHS Prime Medicare Plan Appeals 1-801-595-2037.
- By telephone: – if it is a fast appeal – at 1-800-547-0421.
- In person: UPREHS, 1040 North 2200 West Suite 200, Salt Lake City, Utah 84116

You also have the right to ask us for a copy of information regarding your appeal. You can call Customer Services, or send your request to us at the above address.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. You, your appointed representative, or your prescribing doctor may file a fast appeal.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date we give you a coverage determination. We can give you more time if you have a good reason for missing the deadline. Very often, our Customer Services can take your request over the telephone.

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 coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling our Customer Services number 1-800-547-0421 or, you can fax it to 801-595-4399. Be sure to ask for a *fast, expedited, or 72-hour* review. Remember that if your prescribing doctor 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 get your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will *automatically* go to the Appeal Level 2, 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 get your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give 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 get your request to reconsider our coverage determination. Remember that if you obtained your prescription from an out of network pharmacy, UPREHS will reimburse you only the amount we would have paid for they drug minus your copayment. The remainder is your financial responsibility.

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 get 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 as quickly as your health requires, but no later than 72 hours after we received your appeal.

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 our Plan.

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 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.

How soon must you file your appeal?

You or your appointed representative 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 the independent review organization whose name and address is included in the redetermination notice you get from us.

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 coverage determination, except your prescribing doctor cannot file the request for you, only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under *Asking for a fast decision*. (Remember, that if your prescribing doctor provides a written or oral supporting Statement explaining that you need the fast appeal, the independent review organization will automatically treat you as eligible for a fast appeal.)

How soon must the independent review organization decide?

After the independent review organization gets 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 gets your request to give you 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 gets the request to give you 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 get notice reversing our coverage determination. 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 get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their 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 get notice reversing our coverage determination. 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), so long as the dollar value of the contested Part D benefit meets the minimum requirement provided in the independent review organization's decision.

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. 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 may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to one of the following addresses depending on where you live:

Office of Medicare Hearings and Appeals (Cleveland, Ohio Mid-West Field Office)
 BP Tower, Suite 1300,
 200 Public Square,
 Cleveland, OH 44114-2316
 Phone: 1-866-236-5089

MID-WEST FIELD OFFICE				
<i>Jurisdiction:</i>				
	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	New York New Jersey Puerto Rico Virgin Islands	Delaware Maryland Pennsylvania Virginia West Virginia District of Columbia	Illinois Indiana Ohio Michigan Minnesota Wisconsin

Office of Medicare Hearings and Appeals Irvine, California (Western Field Office)

27 Technology Drive, Suite 100,
 Irvine, CA 92618-2364
 Phone: 1-866-495-7414

WESTERN FIELD OFFICE				
<i>Jurisdiction:</i>				
Utah Wyoming	Iowa Kansas Missouri Nebraska	Colorado Montana North Dakota South Dakota	Arizona California Hawaii Nevada	Alaska Idaho Oregon Washington

Miami, Florida (Southern Field Office)
 100 SE 2nd Street, Suite 1700,
 Miami, FL 33131-2100
 Phone: 1-866-622-0382

SOUTHERN FIELD OFFICE		
Jurisdiction:		
	Alabama Florida Georgia Kentucky Mississippi North Carolina South Carolina Tennessee	Arkansas Louisiana New Mexico Oklahoma Texas

During the Administrative Law Judge review, you may present evidence, review the record (by receiving a copy of the file 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 does not meet the minimum requirement provided in the independent review organization’s decision. If the dollar value is less than the minimum requirement, you may not appeal further.

How is the dollar value (the amount remaining in controversy) calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during our Plan year. Projected value includes your copayments, all costs incurred after your costs exceed the initial coverage limit, and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this 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 get notice reversing our coverage determination.
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 get notice reversing our coverage determination.
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 get notice reversing our coverage determination.

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: The Medicare Appeals Council may review your case

The Medicare Appeals 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 or your appointed representative can request a review by filing a written request with the Council.

The Medicare Appeals Council does not review every 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 get notice reversing our coverage determination.
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 get notice reversing our coverage determination.
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 get notice reversing our coverage determination.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, 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 the minimum requirement 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 meets the minimum requirement provided in the Medicare Appeals Council's decision, 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 get 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 get notice reversing our coverage determination.

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 get notice reversing our coverage determination.

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 get notice reversing our coverage determination.

If the Judge decides against you

The Judge's decision is final and you may not take the appeal any further.