



What to do if you have complaints about your Part D prescription drug benefits

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 Customer Service at 1-888-873-8049. TTY users, please call 1-888-290-3658. Our business hours are:

- March 2, 2007 until November 14, 2007, 8:00 a.m. until 8:00 p.m. Monday– Friday, alternative technologies may be used for weekends, holidays and evenings;
- November 15, 2007 until March 1, 2008, 8:00 a.m. until 8:00 p.m. seven days per week.

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. 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 New West Medicare 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 New West Medicare or one of our network 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 your network 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. For more information about grievances, including how to file a grievance, see the section “How to file a grievance” below.

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. You have the right to ask us for an “exception,” which is a type of coverage determination, if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. **If you request an exception, your physician must provide a statement to support**

your request. For more information about coverage determinations and exceptions, see the section "How to request a coverage determination" below.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. **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 called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable you have additional appeal rights. For more information about appeals, see the section "How to request an appeal" below.

How to file a grievance

If you have a complaint, we encourage you to first call Customer Service at the number listed above. We will try to resolve any complaint that you might have 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 call this the formal grievance procedure.** To use the formal grievance procedure you must submit your written grievance to the Appeals & Grievance Department. Upon receiving the grievance, we will send a written acknowledgment letter within five business days to advise you that the complaint has been received and that New West will address your concerns. You will receive a final written response within 30 days (24 hours if an expedited grievance) of our receipt of the grievance. In some instances, we require additional time to address your concern. If additional time is needed, we will keep you informed of how your grievance is being handled. Whether you use the formal (written) or informal (telephone) grievance procedure, New West tracks all appeals and grievances in order to report data to CMS and to our members, upon request. 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 days after receiving your complaint. We may extend the timeframe by up to 14 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 request a coverage determination

What is the purpose of this section?

This section explains 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 New West Medicare 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 New West Medicare and ask us for a coverage determination. 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. If we 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 coverage determination on your request, it will be automatically

forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

- You ask us to pay for a prescription drug you have already received. This is a request for a coverage determination about payment. You can call us at 1-800-290-3657, option 2 (TTY 1-888-290-3658) to get help in making this request.
- You ask for a Part D drug that is not on our list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can call us at the number above to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**
- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You can call us at the number above to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can call us at the number above to ask for this type of decision. See "What is an exception" below for more information about the exceptions process.
- You ask us to reimburse you for a drug you bought at 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 New West Medicare. You can call us at the number above 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 a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of New West Medicare apply to your specific situation.

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 a number of situations.

- You can ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan.
- 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 our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the alternative drug is included on the plan formulary or the drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your physician must submit a statement supporting your exception request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as 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.

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

Who may ask for a coverage determination?

You can ask us for a coverage determination 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 an *Appointment of Representative* statement (available on this website) that gives the person legal permission to act as your appointed representative. A copy of the form is available for download from this website. This statement must be sent to us at New West Health Services, PO Box 668, Kalispell, MT 59903. You can call us at 1-888-873-8049 (TTY 1-888-290-3658) 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” or “fast” coverage determination

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” coverage determination that is made within the standard time frame (typically within 72 hours; see below), or it can be a “fast” coverage determination 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 call us at 1-800-290-3657, option 2 (TTY 1-888-290-3658). Or, you can deliver a written request to New West Health Services, 130 Neill Ave, Helena MT 59601, or fax it to 406-457-2298.

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 1-800-290-3657, option 2 (TTY 1-888-290-3658). Or, you can deliver a written request to New West Health Services, 130 Neill Ave, Helena MT 59601 or fax it to 406-457-2298. 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 coverage determination 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 coverage determination, 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 coverage determination, we will give you our decision within the 72 hour standard time frame.

What happens when you request a coverage determination?

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

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, 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. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules - such as dosage or quantity limits or step therapy requirements, we must give you 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. **If you are requesting an exception, you should submit your prescribing physician’s supporting statement with the request, if possible.**

We will give you a decision in writing about the prescription drug you have requested. 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.

For a fast coverage determination 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 will give you 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 give you a decision in writing about the prescription drug you have requested. 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 give you 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 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 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 after 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 if we deny your request?

If we deny your request, we will send you a written decision 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 drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1 below.)

How to request an appeal

This section explains what you can do if you disagree with our coverage determination decision.

What kinds of decisions can be appealed?

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, if you think we should have reimbursed you more than you received, or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exceptions 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 level to the next.** At each level, your request for Part D prescription drug 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 any part of your request, 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 sent outside of New West Medicare, where people who are not connected to us review your case 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.

Each appeal level is discussed in greater detail below.

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 us at 1-888-873-8049 (TTY 1-888-290-3658) if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive 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, 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, 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 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:

- In writing, to New West Health Services, 130 Neill Ave, Helena MT 59601
- By fax, at 406-457-2298
- By telephone —if it is a fast appeal—at 1-800-290-3657, option 2 (TTY 1-888-290-3658)
- In person, 130 Neill Ave, Helena MT 59601

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-888-500-3355 (TTY 1-888-290-3658), New West Health Services, Attn: Appeals & Grievances, 130 Neill Ave, Helena MT 59601.

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. A fast appeal may be filed by you, your appointed representative, or your prescribing physician.

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 coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at New West Health Services, Attn: Appeals & Grievances, 130 Neill Ave, Helena, MT 59601. To file a standard appeal, you can call us at 1-888-500-3355 (TTY 1-888-290-3658), or send the appeal to us in writing at the address above.

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 us at 1-888-500-3355 (TTY 1-888-290-3658). Or, you can deliver a written request to New West Health Services, Attn: Appeals & Grievances, 130 Neill Ave, Helena, MT 59601 or fax it to 406-457-2299. Be sure to ask for a "fast," "expedited," or "72-hour" review. (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 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 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 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 receive your request to reconsider 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 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 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 New West Medicare.

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.

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 receive from New West Medicare.

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 physician 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, if your prescribing physician provides a written or oral statement supporting your request for a 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 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 receives 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 receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have given effect to 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 coverage determination. We will also send the independent review organization a notice that we have given effect to 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 receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have given effect to 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 PO Box 2219, Billings, MT 59103-2329.

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 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 any 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 what you would be charged for the drug and the number of refills prescribed for the requested drug during the plan year. Projected value includes your co-payments, all expenditures incurred after your expenditures exceed the initial coverage limit, and expenditures 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 receive 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 receive 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 receive 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: Your case may be reviewed by the Medicare Appeals Council

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 review by filing a written request with the Council.

The Medicare Appeals Council does not review every case it receives. 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 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 receive 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 receive 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 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 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 receive 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 receive 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.