Employees Group Insurance Division

Office of Management and Enterprise Services

Medicare Part D Grievance and Appeals Guide

HealthChoice Employer PDP
High and Low Option Medicare Supplement Plans With Part D

MedicareRx
Prescription Drug Coverage

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This publication is issued by the Office of Management and Enterprise Services as authorized by Title 62, Section 34. Copies have not been printed but are available through the agency website.

Who to Contact About a Grievance or Appeal

Prior Authorization/Exception

Express Scripts
24 hours a day/7 days a week
Toll-free 1-800-935-6103 or toll-free TDD 1-800-825-1230

Pharmacy Appeals (Level 1 Appeals)

HealthChoice Member Services - Ask for the Pharmacy Unit
Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time
1-405-717-8780 or toll-free 1-800-752-9475, Fax 1-405-717-8925
TDD 1-405-949-2281 or toll-free 1-866-447-0436
HealthChoice
Attention: Pharmacy Unit
3545 NW 58 Street, Suite 110
Oklahoma City, OK 73112

Pharmacy Grievances

HealthChoice Member Services
Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time
1-405-717-8780 or toll-free 1-800-752-9475, Fax 1-405-717-8925
TDD 1-405-949-2281 or toll-free 1-866-447-0436
HealthChoice
Attention: Medicare Grievances
3545 NW 58 Street, Suite 110
Oklahoma City, OK 73112

Quality Improvement Organization

Oklahoma Foundation for Medical Quality
Monday through Thursday, 8:00 a.m. to 4:30 p.m., Central time
14000 Quail Springs Parkway, Suite 400
Oklahoma City, OK 73134
1-405-840-2891 or toll-free 1-800-522-3414, Fax 1-405-858-9097
Hearing impaired, please use relay service

Fraud, Waste, and Abuse Reporting

Health Integrity, LLC
Monday through Friday, 8:00 a.m. to 7:00 p.m., Eastern time
Toll-free 1-877-772-3379 or TDD 1-800-855-2880
Email: MEDICinfo@healthintegrity.org

What to do if you Have a Problem or Concern

Introduction and Overview of the Grievance/Complaint and Appeal Processes

This Guide is intended to provide the information you need if you have a problem or concern about your Medicare Part D prescription drug coverage. The Medicare program has set rules about what you need to do to voice a problem or concern, as well as what HealthChoice is required to do when it learns about your problem.

Please let HealthChoice know right away if you have a problem or concern about your Medicare Part D prescription drug coverage. The Plan will work with you to try to find a solution to your problem.

When you contact the Plan about a problem or concern related to your Medicare Part D prescription drug coverage, HealthChoice Member Services will work with you to try to find a satisfactory solution. Contact HealthChoice Member Services at 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436, Monday through Friday 7:30 a.m. - 4:30 p.m.

As a member of Medicare and this Plan, you have certain rights. HealthChoice staff members have pledged to honor your rights, take your problems and concerns seriously, and treat you with respect. HealthChoice must always treat you fairly when handling your issue. You cannot be disenrolled or penalized in any way for voicing a problem or concern. If at any time during the process you feel you need additional help or information, please don't hesitate to contact HealthChoice Member Services at the numbers listed above.

There are two processes for handling problems related to your Medicare Part D prescription drug coverage. One process must be followed when you file a grievance, and a different process must be followed when you ask for a coverage decision, including a prior authorization/ exception or an appeal.

First, you need to know what the phrases *filing a grievance, asking for a coverage decision, asking for a prior authorization/exception,* and *asking for an appeal* mean to you as a member of a Medicare Part D plan.

Grievance/Complaint

A grievance/complaint is the process you use if you have a problem concerning waiting times, customer service, or getting accurate and timely information from HealthChoice or its pharmacy benefits manager, Express Scripts. You can also file a grievance/complaint if you have a

concern with the quality of care you received. **A grievance does not involve coverage or payment for your prescription drugs.**

Coverage Decision

A coverage decision is made each time you ask HealthChoice to cover or pay for your prescription drugs. HealthChoice makes a coverage decision when you:

- Ask for a prescription from your pharmacy or other provider
- Ask for a prior authorization/exception
- Ask HealthChoice to pay you back for a drug you already purchased
- Ask for an appeal

If you disagree with the Plan's decision, you can file an appeal.

Prior Authorization/Exception

A prior authorization/exception is required before HealthChoice will cover certain drugs, even though they are listed in the HealthChoice Medicare Formulary. Prior authorization/exception also refers to the process you use if you ask HealthChoice to make a coverage decision and change its pharmacy benefit rules or restrictions. Examples include when you:

- Request a brand-name medication when a generic alternative is available
- Are prescribed a medication that has certain restrictions, such as age or gender
- Are prescribed a medication dosage that is different than current prescribing guidelines

If you disagree with the Plan's decision, you can file an appeal.

Appeal

An appeal is a formal way of asking HealthChoice to review and change its decision about covering your prescription drugs. Anytime HealthChoice makes a decision about covering or paying for your prescription drugs and you are unhappy with the decision, you can file an appeal. There are five levels of appeal. For an explanation of the different levels of appeal, go to the *Appeals* section of this guide starting on page 14.

If You Need Help During the Grievance or Appeal Processes

If you need help during any part of the process, please contact HealthChoice Member Services at 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

In the event a Member Services Representative cannot answer your question or resolve your problem, they can let you know who to contact.

At each step of the grievance or appeal processes, a letter is sent to you that provides information about what to do if you disagree with the Plan's decision and want to continue to the next level of appeal. This letter is sent to you if we received your grievance in writing, if your grievance is a quality of care issue, or if you request a response in writing.

There are also other people who can help you during the grievance or appeal process.

- Your doctor or prescriber may act on your behalf by making a request for a prior authorization/exception. Your provider must give medical reasons to support any request for a prior authorization/exception or appeal.
- Your appointed representative, such as a relative or friend, can act for you. See *Appointing a Representative* below.
- Your lawyer can act on your behalf, but you are not required to hire a lawyer.

Appointing a Representative

To appoint a representative to act on your behalf, you can complete a HealthChoice Medicare Part D *Appointment of Representative* form which is available on the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**. To locate the form, go the *Member* tab in the top menu bar, click *Medicare Members* from the drop down box and the scroll to *Forms and Applications*.

You can also request a form by contacting HealthChoice Member Services at 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

You can also send a letter to HealthChoice appointing your representative. Make sure your letter includes:

- Your name, address, and telephone number

- Your Medicare ID number
- Your HealthChoice ID number
- The name, address, and telephone number of the person you are appointing to represent you
- A statement that you are authorizing the person to act on your behalf, and a statement authorizing HealthChoice to release personal health information to your representative

Your letter must be signed and dated by you and the person you are appointing. Your representative must also include a statement indicating they accept the appointment.

Please return your letter or form to:

HealthChoice
Attention: Pharmacy Unit
3545 NW 58 Street, Suite 110
Oklahoma City, OK 73112

If you appoint someone to represent you and act on your behalf, you must also complete and submit a *HIPAA Authorization to Disclose HealthChoice Information* form. This form gives HealthChoice the authority to disclose your personal health information to your appointed representative. This form is available on the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**. To locate the form, go the *Member* tab in the top menu bar, click *Medicare Members* from the drop down box, then scroll to *Forms and Applications*.

Filing a Grievance/Complaint

You must notify HealthChoice within 60 days of your problem if you want to file a grievance/complaint.

Filing a grievance/complaint is the same as voicing a problem or concern. A grievance/complaint does not involve issues about coverage or payment for your prescription drugs. If you have a coverage or payment issue, see *Asking for a Coverage Decision.*

If you have a grievance/complaint, call HealthChoice Member Services. When possible, a Member Services Representative will respond to your problem over the phone, or let you know if there is anything else you need to do. You can also ask HealthChoice to respond to your concern in writing. Contact HealthChoice Member Services by calling 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

If you would prefer to put your grievance/complaint in writing, please mail it to:

HealthChoice
Attention: Medicare Grievances
3545 NW 58 Street, Suite 110
Oklahoma City, Oklahoma 73112

If you submit your grievance/complaint in writing, HealthChoice will respond to you in writing.

If your grievance/complaint cannot be resolved over the phone or if you voice your concerns in writing, HealthChoice reviews your grievance through a grievance process. HealthChoice must give you its decision as quickly as possible based on your health status, but no later than 30 days of its receipt of your grievance/complaint. You or HealthChoice can extend this deadline for up to 14 additional days if the need for more information is justified and the delay is in your best interest.

Be aware that HealthChoice must respond to your grievance/complaint within 24 hours if:

- HealthChoice denies your request for a fast coverage determination or a fast coverage redetermination, or
- You have not yet purchased or received the drug in dispute

Reasons to File a Grievance/Complaint

If you have a problem with the quality of care you received, you have the option to file your grievance/complaint with HealthChoice, the Quality Improvement Organization (QIO), or both organizations. Quality of care issues are numbers 1 through 4 and they are indicated by a blue asterisk.* See *Filing a Grievance/Complaint with the Quality Improvement Organization*.

If you have a problem with any of the issues listed in numbers 5 through 16, you must file your grievance/complaint with HealthChoice.

The grievance/complaint process is used when you have problems with the quality of your care or customer service you received. The Medicare program sets rules about what you need to do to file a grievance/complaint and what HealthChoice is required to do when it receives a grievance/complaint.

1. You are unhappy with the quality of care you received.*
2. You think coverage for your hospital stay, home health care, skilled nursing facility care, or outpatient rehabilitation is ending too soon.*
3. You were given the wrong drug or the wrong dosage of a drug.*
4. You are allergic to or interacted in a negative way to a drug you were given.*
5. You believe your privacy was not respected or someone shared your health information.
6. You believe you have been encouraged to leave (disenroll from) HealthChoice.
7. You are unhappy with the customer service you received.
8. You were kept waiting too long on the telephone or at the pharmacy.
9. You think someone has been rude or disrespectful to you.
10. You believe HealthChoice failed to provide notices as required by Medicare.
11. You believe HealthChoice failed to follow Medicare's rules.
12. You think information HealthChoice provided to you is hard to understand.
13. You question the cleanliness or condition of a Network Pharmacy.
14. Your request for a fast response to a coverage decision or appeal was denied.
15. You did not receive a decision within the required time frame.
16. Your case was not sent to the Independent Review Entity when HealthChoice failed to give you its decision within the required time frame.

Filing a Grievance/Complaint with the Quality Improvement Organization

The Oklahoma Foundation for Medical Quality is the Quality Improvement Organization (QIO) for Oklahoma. Only grievances/complaints related to the quality of care you received can be reported to the Oklahoma Foundation for Medical Quality. Quality of care issues are listed on the previous page and are indicated by a blue asterisk.* See *Reasons to File a Grievance*.

The Quality Improvement Organization (QIO) is a company that is paid by Medicare to check on the quality of care for people enrolled in Medicare.

If you have a grievance/complaint about the quality of care you received, you can file a grievance with HealthChoice, the Oklahoma Foundation for Medical Quality, or both organizations. Anytime a grievance/complaint is filed with the Quality Improvement Organization, HealthChoice must cooperate in resolving your problem.

To file a grievance/complaint with the Oklahoma Foundation for Medical Quality, call toll-free 1-800-522-3414 and ask for the Beneficiary Protection Unit. You need to provide your name, address, phone number, and a brief explanation of your grievance. A packet of information is then sent to you that includes the necessary forms and instructions for filing a formal grievance.

Your grievance/complaint must be reported within 60 days of the event that led to your issue.

If you prefer to put your grievance/complaint in writing, include your name, address, phone number, and a brief explanation of your issue. Mail your grievance to:

Oklahoma Foundation for Medical Quality
Attention: Beneficiary Protection Unit
14000 Quail Springs Parkway, Suite 400
Oklahoma City, Oklahoma 73134

Asking for a Coverage Decision/Determination

When HealthChoice makes a coverage decision, also called a coverage determination, it is making a decision about whether or not to cover your drug, how much it will pay, and your share of the cost (your copay).

HealthChoice also makes a coverage decision/determination each time you ask for a prior authorization/exception to the Plan's coverage rules or restrictions.

Usually, when you ask for a coverage decision, HealthChoice covers your drug and pays its share of the cost; however, in some cases, the Plan may decide that a drug is not covered, or is not medically necessary, or the Plan has certain coverage rules or restriction that apply to your drug.

If you want HealthChoice to reimburse you for a drug you already paid for, see *Asking HealthChoice to Pay You Back for a Drug You Already Purchased.*

If HealthChoice denies coverage or you are unhappy about the way the Plan decides to cover your drug, you can ask for a prior authorization/exception.

Asking for a Prior Authorization/Exception

HealthChoice has rules and restrictions that apply to the way drugs are or are not covered. If you disagree with these rules or restrictions, you can ask HealthChoice for a prior authorization/exception. When you ask for a prior authorization/exception, you are asking HealthChoice to make an exception to its rules or restrictions and cover your medication.

Your request can be made by calling, writing a letter, or by completing a *Pharmacy Request for Coverage Determination* form. If you decide to write a letter, please include your HealthChoice member ID number. If you decide to complete the coverage determination form, it is available on our website at **www.sib.ok.gov** or **www.healthchoiceok.com**. To locate the form, click the *Member* tab in the top menu bar and select *Medicare Members*, then scroll down to *Forms and Applications*.

If the Plan denies your request for a prior authorization/exception, you can file an appeal. See *Asking for a Level 1 Appeal*.

Prior Authorization/Exception for a Covered Drug

Certain drugs listed in the HealthChoice Medicare Formulary require a prior authorization/exception before they are covered by the Plan. Generally, these drugs are very high cost, have specific prescribing guidelines, are usually used for cosmetic purposes, or might be covered under Medicare Part B.

To request a prior authorization/exception for a covered drug, your doctor must contact Express Scripts, the HealthChoice pharmacy benefits manager, and provide information to support your request. Your doctor can contact Express Scripts toll-free at 1-800-935-6103.

Prior Authorization/Exception to the Plan's Quantity Limitation Rules

Due to approved therapy guidelines, certain medications have set quantity limits. Quantity limitations can also apply if the medication form is other than a tablet or capsule.

To request a prior authorization/exception to the Plan's quantity limitation rules, your doctor must contact Express Scripts, the HealthChoice pharmacy benefits manager, and provide information to support your request. Your doctor can contact Express Scripts toll-free at 1-800-935-6103.

Prior Authorization/Exception for a Non-Formulary or Non-Covered Drug

If you want HealthChoice to cover a non-formulary drug (a drug not listed on the HealthChoice Medicare Formulary) or a non-covered drug, you must ask for a prior authorization/exception.*

To request a prior authorization/exception for a non-formulary or non-covered drug, contact Express Scripts Prior Authorization line toll-free at 1-800-935-6103 or TDD 1-800-825-1230.

If your request for coverage of a non-formulary or non-covered drug is approved, you must pay the higher non-Preferred copay. To request a lower copay, you must complete a second prior authorization/exception process. See *Prior Authorization/Exception for a Tier Exception to Receive a Lower Copay*.

*Please note that HealthChoice does not cover all prescription drugs, and some drugs are excluded from coverage. In some instances, Medicare does not allow the Plan to cover certain drugs, and in other instances, HealthChoice has decided not to cover certain drugs.

Prior Authorization/Exception for a Tier Exception to Receive a Lower Copay

If you choose a non-Preferred medication when a Preferred medication is available, you must pay the higher non-Preferred copay unless you request a prior authorization/exception. When you request a lower copay, this is called a tier exception. Be aware that medical guidelines must be met and information supplied by your doctor must justify your request.

To request a prior authorization/exception to receive a lower copay, your doctor must contact Express Scripts, the HealthChoice pharmacy benefits manager, and provide information to support your request. Your doctor can contact Express Scripts toll-free at 1-800-841-5409 or TDD 1-800-871-7138.

Prior Authorization/Exception to the Step Therapy Process

Step Therapy requires you to try a specific, cost effective medication to treat your medical condition before HealthChoice will cover another drug that is more costly. If you disagree with the Step Therapy process, you can ask HealthChoice for a prior authorization/exception.

To request a prior authorization/exception to the Step Therapy process, your doctor must contact Express Scripts, the HealthChoice pharmacy benefits manager, and provide information to support your request. Your doctor can contact Express Scripts toll-free at 1-800-935-6103 or TDD 1-800-825-1230.

Time Frames for Coverage Decisions

Standard Decision Time Frame

Generally, when you ask Express Scripts for a prior authorization/exception, they will make a decision and give you an answer within the standard decision time frame of 72 hours of their receipt of your request.

If Express Scripts says yes to part or all of your request for a prior authorization/exception, the authorization is loaded into the computer system within 72 hours.

If Express Scripts says no to your request for a prior authorization/exception, a letter that explains the reasons for the denial is sent to you. You have the right to appeal their decision. See *Asking for a Level 1 Appeal*.

When you ask for a prior authorization/exception, you must decide if you need a *standard* decision or a *fast (expedited)* decision.

When you ask for a *standard* decision, you receive an answer within 72 hours. When you ask for a *fast* decision, you receive an answer within 24 hours.

Fast (Expedited) Decision Time Frame

If you or your doctor believes that waiting the standard decision time frame of 72 hours could harm your health or hurt your ability to function, you or your doctor can ask HealthChoice for a fast (expedited) decision.* If you ask for a fast decision, the Plan must give you an answer within 24 hours or sooner if required due to your health status. If HealthChoice does not meet this deadline, it must send your request to Level 2 of the appeals process.

If your doctor or other prescriber tells HealthChoice that your health status requires the Plan to make a fast decision, the Plan automatically gives you a fast decision within 24 hours of its receipt of your request.

If you ask for a fast decision on your own, without the support of your doctor or other prescriber, the Plan decides whether your health status requires a fast decision.

If HealthChoice says yes to part or all of your request for a fast decision, the prior authorization/ exception is loaded into the computer system within 24 hours.

If the Plan says no to your request for a fast decision, a letter is sent to you that explains the reasons for giving you a standard decision rather than a fast decision. The letter also explains how you can ask for a fast grievance and ask for an answer within 24 hours. See *Filing a Grievance*.

*You cannot ask for a fast decision for a drug you already purchased.

Asking HealthChoice to Pay You Back for a Drug You Already Purchased

An event may occur that requires you to pay for a prescription drug and then ask HealthChoice to pay you back. When you ask HealthChoice to pay you back for a drug you already purchased, it is a type of coverage decision. Examples of when you might need to pay the full cost for a drug include:

- You use a non-Network pharmacy.
- You don't have your pharmacy ID card available when filling your prescription.
- You have other prescription drug coverage that is primary over your HealthChoice coverage.
- You pay the full cost for a drug for other reasons.

The standard decision time frame always applies to requests for reimbursement.

To ask HealthChoice for reimbursement, send a letter or a *Pharmacy Direct Claim Form* and your pharmacy receipt to:

Express Scripts
P.O. Box 14718
Lexington, KY 40512

If you decide to write HealthChoice for reimbursement, please include your HealthChoice member ID number. If you decide to use the *Pharmacy Direct Claim Form*, it is available on our website at **www.sib.ok.gov** or **www.healthchoiceok.com**. To locate the form, click the *Member* tab in the top menu bar and select *Medicare Members*, then scroll down to *Forms and Applications*.

If Your Request is Approved

If the drug you paid for is a covered drug and meets plan guidelines, HealthChoice sends you payment for its share of the cost. HealthChoice is required to notify you of its decision within the standard decision time frame of 72 hours and send payment to you within 30 days of its receipt of your request.

If Your Request is Denied

If HealthChoice denies your request, a letter that explains the reasons for the denial is sent to you. You can choose to accept this decision or file a Level 1 Appeal. The letter that explains the reasons for the denial also provides information about how you can request a Level 1 Appeal. See *Asking for a Level 1 Appeal*.

Asking for a Level 1 Appeal (Coverage Redetermination)

If your request for a prior authorization/exception is denied, you can ask the Plan to reconsider by requesting a Level 1 Appeal.

If HealthChoice denies your request for a prior authorization/exception, you can ask the Plan to review and reconsider its coverage decision. This is called a Level 1 Appeal or a coverage redetermination.

When HealthChoice reviews your appeal, all the information you and/or your doctor provided in your first request will be reviewed again. The Plan also checks to see if it was fair in following the rules when it denied your first request. During the appeals process, you may need to provide HealthChoice with more information.

You must ask for a Level 1 Appeal/coverage redetermination within 60 calendar days of the date on the letter that notified you of the denial of your first request. If you miss this deadline but have a good reason for missing it, HealthChoice can extend this deadline.

To ask for a redetermination, you must contact HealthChoice Member Services at 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436. Please ask for the Pharmacy Unit.

A written request can be made using the *Pharmacy Request for Redetermination* form available on our website at **www.sib.ok.gov** or **www.healthchoiceok.com**. To locate the form, click the *Member* tab in the top menu bar and select *Medicare Members*, then scroll down to *Forms and Applications*.

You can also send HealthChoice a letter requesting a coverage redetermination. If you decide to write to HealthChoice, please include your member ID number, the name of the drug you want covered, and the reasons why you are appealing. Send your request to:

HealthChoice
Attention: Pharmacy Unit
3545 NW 58 Street, Suite 110
Oklahoma City, OK 73112

or you can fax your request for an appeal to 1-405-717-8925.

You have the right to gather and include additional information in your request. You also have the right to ask HealthChoice for a copy of its information regarding your appeal; however, there may be a fee for copying and mailing as allowed by law.

Time Frames for a Level 1 Appeal

Standard Decision Time Frame

Generally, when you ask for a Level 1 Appeal, HealthChoice makes a decision and gives you an answer within the standard time frame of seven calendar days of its receipt of your appeal. If HealthChoice does not give you an answer within seven calendar days, the Plan must send your appeal to Level 2 of the appeals process.

If HealthChoice says yes to part or all of your appeal, the Plan must provide coverage as quickly as your health requires but no later than seven calendar days of its receipt of your appeal.

Fast (Expedited) Decision Time Frame

If your doctor or other prescriber believes that waiting the standard seven days could harm your health or hurt your ability to function, you can ask HealthChoice for a fast appeal.*

When you ask for a fast appeal, the Plan must give you an answer within 72 hours or sooner if required due to your health status. If HealthChoice does not meet this deadline, the Plan must send your request to Level 2 of the appeals process.

If HealthChoice says yes to part or all of your appeal, the Plan must provide coverage as quickly as your health status requires but no later than 72 hours of its receipt of your appeal.

If Your Level 1 Appeal is Denied

If the Plan says no to your Level 1 Appeal, a letter that explains the reasons for the denial is sent to you. You can choose to accept this decision or file a Level 2 Appeal. The letter that explains the reasons for the denial also provides information about how you can request a Level 2 Appeal.

*You cannot ask for a fast appeal for a drug you already purchased.

Asking for a Level 2 Appeal

At this second level of appeal, a review is performed by an outside Independent Review Organization that is hired by Medicare. This organization is not a government agency and has no connection to HealthChoice. Medicare oversees the work the Independent Review Organization performs.

If your Level 1 Appeal is denied or the Plan refuses to pay you back for a drug you already paid for, you can ask for a Level 2 Appeal.

When HealthChoice receives your request for a Level 2 Appeal, it sends all the information about your appeal to the review organization. This information is called your case file. You have the right to ask HealthChoice for a copy of your case file; however, there may be a fee for copying and mailing as allowed by law.

The people at the review organization perform a careful review of all the information in your case file. They then consider the decision HealthChoice made. The Independent Review Organization gives you its decision in writing and includes the reasons for its decision.

You must ask for a Level 2 Appeal in writing within 60 calendar days of the letter that notified you of the denial of your Level 1 Appeal. The letter you receive that explains the reasons for the denial provides instructions for filing a Level 3 Appeal.

Time Frames for a Level 2 Appeal

Standard Decision Time Frame

Generally, when you ask for a Level 2 Appeal, the review organization makes a decision and gives you an answer within the standard time frame of seven calendar days of its receipt of your appeal.

If the review organization says yes to part or all of your appeal, the Plan must provide the coverage the Independent Review Organization approved within 72 hours of its receipt of the organization's decision.

Fast (Expedited) Decision Time Frame

If your health status requires it, you can ask the Independent Review Organization for a fast appeal.* When you ask for a fast appeal, the review organization must give you an answer within 72 hours of its receipt of your appeal.

If the review organization says yes to part or all of your appeal, the Plan must provide the coverage the Independent Review Organization approves within 24 hours of its receipt of the organization's decision.

If Your Level 2 Appeal is Denied

If the review organization says no to your Level 2 Appeal, it means they agree with the Plan's decision to deny your request. This is also called upholding the decision or turning down your appeal.

If you want to file a Level 3 Appeal, the coverage value in dispute must be at least $140. The letter you receive that explains the reasons for the denial tells you if your case meets the minimum requirements and provides information about how you can request a Level 3 Appeal.

If the dollar value of the coverage you are requesting does not meet the minimum coverage value, you cannot make another appeal, and the decision made at Level 2 is final.

*You cannot ask for a fast decision for a drug you already purchased.

Level 3, 4, and 5 Appeals

Asking for a Level 3 Appeal

Level 3 Appeals are conducted by an administrative law judge (ALJ). A hearing before an ALJ allows you to present you case for another independent review. The ALJ must review the facts of your appeal and listen to your testimony before making a decision. ALJ hearings are usually held over the phone; however, they can also be held by video conference or, in some cases, in person. During the review, you can present evidence, review the record, and be represented by counsel.

For each of the three remaining levels of appeal, the process works in much the same way as in Level 1 and Level 2 Appeals.

To ask for a Level 3 Appeal the coverage value in dispute must be at least $140. The letter you receive that explains the reasons for the previous denial tells you if your case meets the minimum requirements.

You must ask for a review by an administrative law judge in writing within 60 calendar days of the letter that notified you of the denial of your Level 2 Appeal. You can request the ALJ extend this deadline if you have a good reason.

If the administrative law judge says yes to your appeal, the appeals process is over and your request is approved.

If the administrative law judge says no to your appeal, a letter that explains the reasons for the denial is sent to you. You can choose to accept this decision or file a Level 4 Appeal. The letter that explains the reasons for the denial also tells you if the rules allow you to go on to a Level 4 Appeal. If the rules allow you to go on to the next level of appeal, the letter provides information about who to contact and what you need to do next.

Asking for a Level 4 Appeal

When you ask for a Level 4 Appeal, you ask for review and reconsideration by the Medicare Appeals Council. The Medicare Appeals Council does not review every case, so your case may or may not be reviewed. There is no minimum dollar value required for this review.

You must ask for review by the Medicare Appeals Council in writing within 60 calendar days of the letter that notified you of the denial of your Level 3 Appeal.

If the council reviews your case and says yes to your request, the appeals process is over and your request is approved.

If the Medicare Appeals Council says no to your appeal, a letter that explains the reasons for the denial is sent to you. You can accept this decision or file a Level 5 Appeal in a federal district court.

The letter that explains the reasons for the denial also tells you if the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on to a Level 5 Appeal, your denial letter provides information about who to contact and what you need to do next.

If the coverage value is less than $1,400,* the Medicare Appeals Council's decision is final and you cannot take your appeal any further.

Asking for a Level 5 Appeal

If the coverage amount involved is $1,400* or more, you can ask for a Level 5 Appeal with a federal district court judge. You must ask for a Level 5 Appeal within 60 calendar days of the letter that notified you of the denial of your Level 4 Appeal. The letter you get from the Medicare Appeals Council provides information about how to request a Level 5 Appeal.

The judge's decision in a Level 5 Appeal is final and you cannot take your appeal any further.

*This amount is adjusted annually.

The chart on the next page shows the Medicare Part D Appeals Process.

Medicare Part D Appeal Processes

Coverage Decision
You ask HealthChoice for a Prior Authorization/Exception to its Pharmacy Rules

Standard time frame – 72 Hours
Fast time frame – 24 Hours

Level 1 Appeal
You ask HealthChoice to Reconsider its Decision

60 Days to File

Standard time frame – 7 Days
Fast time frame – 72 Hours

Level 2 Appeal
You ask for a Review by the Independent Review Organization

60 Days to File

Standard time frame – 7 Days
Fast time frame – 72 Hours

Level 3 Appeal
You ask for a Review by a Federal Administrative Law Judge

60 Days to File

The coverage amount must be greater than $140

Level 4 Appeal
You ask for a Review by the Medicare Appeals Council

60 Days to File

If the council doesn't rule in your favor, you can file a Level 5 Appeal

Level 5 Appeal
You ask for a Review by a Federal District Judge

60 Days to File

The coverage amount must be greater than $1,400